

## SETTLEMENT AGREEMENT AND RELEASE

This Settlement Agreement and Release (“Agreement”) is made and entered into this 6th day of March 2020, by and among (1) Plaintiff Lackawanna Chiropractic P.C. (“Plaintiff”), individually and on behalf of the Settlement Class, and (2) Defendant Tivity Health Support, LLC (“Tivity”), subject to preliminary and final approval as required by Rule 23 of the Federal Rules of Civil Procedure. As provided herein, Plaintiff, Class Counsel, and Tivity hereby stipulate and agree that, in consideration of the promises and covenants set forth in this Agreement and upon the Effective Date, all Released Claims, including those claims asserted in the action titled, *Lackawanna Chiropractic P.C. v. Tivity Health Support, LLC*, Case No. 1:18-cv-00649-LJV-JJM (W.D.N.Y.) (the “Action”), shall be settled and compromised upon the terms and conditions contained herein.

### **I. Recitals**

1. On June 7, 2018, Plaintiff initiated this litigation against Tivity in the United States District Court for the Western District of New York, alleging violations of the Telephone Consumer Protection Act (“TCPA”), 47 U.S.C. § 227, and seeking, *inter alia*, monetary damages. [DE #1].
2. Tivity at all times has denied and continues to deny any wrongdoing whatsoever and has denied and continues to deny that it violated the TCPA, or committed any other wrongful act or violation of law.
3. Plaintiff believes that the claims asserted in the Action have merit. Nonetheless, Plaintiff and Class Counsel recognize and acknowledge the expense, time, and risk associated with continued prosecution of the Action through class certification, trial, and any subsequent appeals. Plaintiff and Class Counsel also have taken into account the uncertainty, difficulties, and delays inherent in litigation, especially in complex actions. Therefore,

Plaintiff and Class Counsel believe that it is desirable that the Released Claims be fully and finally compromised, settled, dismissed with prejudice, and barred pursuant to the terms set forth herein. Based on their evaluation, Plaintiff and Class Counsel have concluded that the terms and conditions of this Agreement are fair, reasonable, and adequate for the Settlement Class, and that it is in the best interests of the Settlement Class to settle the Released Claims pursuant to the terms and provisions of this Agreement.

4. The Parties now agree to settle the Action in its entirety, without any admission of liability, with respect to all Released Claims, as defined below. The Parties intend this Agreement to bind Plaintiff, the Releasing Parties, all members of the Settlement Class who do not timely request to be excluded from the Settlement, and Tivity.

**NOW, THEREFORE**, in light of the foregoing, for good and valuable consideration, the receipt of which is hereby mutually acknowledged, the Parties agree, subject to approval by the Court, as follows.

## **II. Definitions**

In addition to the terms defined at various points within this Agreement, the following defined terms apply throughout this Agreement:

5. “Action” means *Lackawanna Chiropractic P.C. v. Tivity Health Support, LLC*, Case No. 1:18-cv-00649-LJV-JJM (W.D.N.Y.).
6. “Approved Claim” means a Claim Form submitted by a member of the Settlement Class that: (a) is received by the Settlement Administrator or postmarked on or before the Claims Deadline; (b) is fully completed by the member of the Settlement Class, with all of the information requested in the Claim Form, and in accordance with the directions on the Claim Form; (c) is signed by the member of the Settlement Class, physically or

electronically, under penalty of perjury; and (d) is verified by the Settlement Administrator pursuant to the provisions of this Agreement as a valid claim eligible to receive payment from the Settlement Funding under the Agreement and the Final Approval Order.

7. “Approved Claim Payment” means the payment that each member of the Settlement Class that submits an Approved Claim will receive. Each Settlement Class Member who timely files with the Settlement Administrator a Claim Form that is determined by the Settlement Administrator to be an Approved Claim pursuant to the provisions of this Agreement shall receive a cash payment of \$320.
8. “Claim Form” means a document substantially in the form set forth in Exhibit 3, as approved by the Court, to be completed by members of the Settlement Class who wish to file a claim to obtain an Approved Claim Payment.
9. “Class Counsel” means:

Avi R. Kaufman  
KAUFMAN P.A.  
400 NW 26<sup>th</sup> Street  
Miami, FL 33127

Stefan Coleman  
LAW OFFICES OF STEFAN COLEMAN, P.A.  
11 Broadway, Suite 615  
New York, NY 10001
10. “Claims Deadline” means the last day that members of the Settlement Class may submit a timely Claim Form to the Settlement Administrator. The Claims Deadline shall be 14 days after the Final Approval Hearing. The Claims Deadline will be specified in the Notice.
11. “Class Period” means the period beginning on June 7, 2014 and ending on the date that a Preliminary Approval Order is entered.
12. “Class Representative” means Lackawanna Chiropractic P.C.

13. “Court” means the United States District Court for the Western District of New York.
14. “Effective Date” means the fifth business day after which all of the following events have occurred:
  - a. The Court has entered without material change the Final Approval Order; and
  - b. The time for seeking rehearing or appellate or other review has expired, and no appeal or petition for rehearing or review has been timely filed; or the Final Approval Order is affirmed on appeal or review without material change, no other appeal or petition for rehearing or review is pending, and the time period during which further petition for hearing, review, appeal, or certiorari could be taken has finally expired and relief from a failure to file same is not available.
15. “Fax List” means the list of all the facsimile numbers to which the Tivity Faxes were sent.
16. “Final Approval” means the date that the Court enters an order and judgment granting final approval to the Settlement and determines the amount of fees and costs awarded to Class Counsel and the amount of a Service Award to the Class Representative, if any. In the event that the Court issues separate orders addressing the foregoing matters, then Final Approval means the date of the last of such orders.
17. “Final Approval Order” means the order and final judgment, substantially in the form set forth in Exhibit 5, which the Court enters upon Final Approval.
18. “Notice” means the notices of proposed class action settlement that the Parties will ask the Court to approve in the Preliminary Approval Order.
19. “Notice Program” means the methods provided for in this Agreement for giving the Notice and consists of a Notice provided by mail (“Mailed Notice”) and a Notice provided through the Settlement Website (“Long-Form Notice”). The form of the proposed Mailed Notice



and Long-Form Notice agreed upon by Class Counsel and Tivity, subject to Court approval, are attached as Exhibits 1 and 2.

20. “Opt-Out and Objection Deadline” means the date by which a written objection to the proposed Settlement, or request for exclusion from the Settlement, must be postmarked, which shall not be less than 30 days prior to the Final Approval Hearing. The Opt-Out and Objection Deadline will be specified in the Notice.
21. “Parties” means Plaintiff and Tivity.
22. “Plaintiff” means Lackawanna Chiropractic P.C.
23. “Preliminary Approval” means the date that the Court enters, without material change, the Preliminary Approval Order.
24. “Preliminary Approval Order” means an order entered by the Court preliminarily approving the Settlement and authorizing the Notice Program, substantially in the form set forth in Exhibit 4.
25. “Released Claims” means any and all actual, potential, filed, known or unknown (including Unknown Claims), fixed or contingent, claimed or unclaimed, asserted or unasserted, suspected or unsuspected, claims, demands, liabilities, rights, causes of action, contracts or agreements, extra-contractual claims, damages, punitive, exemplary, or multiplied damages, expenses, costs, attorneys’ fees and or obligations, whether in law or in equity, accrued or unaccrued, direct, individual or representative, of every nature and description whatsoever, whether based on federal, state, or local statutory or common law, or any other law, rule, or regulation, against the Released Parties, or any of them, arising from Tivity Faxes.

26. “Released Parties” means Tivity, its present, former, and future parents, subsidiaries, and affiliates, and the predecessors, successors, assigns, employees, agents, representatives, consultants, independent contractors, vendors, insurers, directors, managing directors, officers, partners, principals, members, attorneys, accountants, financial and other advisors, investment bankers, underwriters, shareholders, lenders, and auditors of any of the foregoing.
27. “Releasing Parties” means Plaintiff and the Settlement Class Members (whether or not such members submit Claim Forms). To the extent that a Settlement Class Member is not an individual, “Releasing Parties” also includes all of its present, former, and future predecessors, successors, assigns, parents, subsidiaries, and affiliates, and all employees, agents, representatives, consultants, independent contractors, insurers, directors, managing directors, officers, partners, principals, and members of any of the foregoing. To the extent the Settlement Class Member is an individual, “Releasing Parties” also includes any present, former, and future spouses, as well as the present, former, and future heirs, executors, estates, administrators, representatives, agents, attorneys, partners, successors, predecessors, and assigns of each of them, and any other representatives of any of the foregoing.
28. “Settlement” means the settlement embodied in this Agreement.
29. “Settlement Administrator” means a third-party notice and claims administrator mutually agreed upon by Class Counsel and Tivity. The Parties have selected and will request approval of Angeion Group by the Court.
30. “Settlement Class” is defined in paragraph 39 hereof.

31. “Settlement Class Member” means any person or entity included in the Settlement Class who files a Claim Form and/or who does not opt-out of the Settlement.
32. “Settlement Costs” means (a) the costs of the Settlement Administrator incurred pursuant to the contract between the Settlement Administrator and Tivity; (b) the Service Award, if any, approved by the Court; and (c) the attorneys’ fees and costs awarded to Class Counsel by the Court, if any.
33. “Settlement Funding” means the funds to be made available by Tivity for Approved Claim Payments.
34. “Settlement Website” means the website that the Settlement Administrator will establish as soon as practicable following entry of the Preliminary Approval Order, but prior to the commencement of the Mailed Notice, as a means for members of the Settlement Class to obtain notice of and information about the Settlement, through and including access to this Agreement, the Long-Form Notice, the Preliminary Approval Order, and such other documents as Class Counsel and Tivity agree to post or that the Court orders posted on the Settlement Website. These documents shall remain on the Settlement Website at least until Final Approval. The URL of the Settlement Website shall be [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com), or such other URL as Class Counsel and Tivity agree upon in writing. The Settlement Website shall not include any advertising, and shall not bear or include the Tivity logo or Tivity trademarks. Ownership of the Settlement Website URL shall be transferred to Tivity within 10 days of the date on which operation of the Settlement Website ceases.
35. “Tivity” means Tivity Health Support, LLC.
36. “Tivity Counsel” means

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BOND, SCHOENECK & KING, PLLC  
Avant Building, Suite 900  
200 Delaware Avenue  
Buffalo, New York 14202

David C. Layden  
JENNER & BLOCK LLP  
353 N. Clark Street  
Chicago, Illinois 60654

37. “Tivity Fax” means the 1,720 faxes that were sent to the fax numbers that appear on the Fax List. Representative examples of the Tivity Faxes are attached as Exhibit 6.
38. “Unknown Claims” means claims that could have been raised in the Action arising from Tivity Faxes and that the Plaintiff or any or all other Releasing Parties, or any of them, do not know or suspect to exist, which, if known by him, her or it, might affect his, her or its agreement to release the Released Parties pursuant to the provisions of this Agreement, or might affect his, her, or its decision to agree, object or not to object to the Settlement. Upon the Effective Date, Plaintiff and all other Releasing Parties shall be deemed to have, and shall have, expressly waived and relinquished, to the fullest extent permitted by law, the provisions, rights and benefits of § 1542 of the California Civil Code, which provides as follows:

A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR.

Upon the Effective Date, Plaintiff and all other Releasing Parties also shall be deemed to have, and shall have, waived any and all provisions, rights and benefits conferred by any law of any state or territory of the United States, or principle of common law, or the law of

any jurisdiction outside of the United States, which is similar, comparable or equivalent to § 1542 of the California Civil Code. Plaintiff and the other Releasing Parties acknowledge that they may discover facts in addition to or different from those that they now know or believe to be true with respect to the subject matter of this release, but that it is their intention to finally and forever to settle and release the Released Claims pursuant to the provisions of this Agreement, notwithstanding any Unknown Claims they may have, as that term is defined in this paragraph.

### **III. Certification of the Settlement Class**

39. For settlement purposes only, Plaintiff and Tivity agree to ask the Court to certify the following “Settlement Class” under Rules 23(b)(3) and (e) of the Federal Rules of Civil Procedure:

All individuals and entities within the United States who were sent a Tivity Fax by or on behalf of Tivity recruiting a provider offering chiropractic services, physical therapy, occupational therapy, speech therapy, acupuncture, massage, and/or complementary and alternative medicine (CAM) services to join a Tivity network.

The following persons and entities are excluded from the Settlement Class: (1) the trial judge presiding over this case; (2) Tivity, as well as any parent, subsidiary, affiliate or control person of Tivity, and the officers, directors, agents, servants or employees of Tivity; (3) any of the Released Parties; (4) the immediate family of any such person(s); (5) any member of the Settlement Class who has timely opted out of the Settlement; and (6) Class Counsel and their employees.

### **IV. Settlement Relief**

40. Tivity agrees to make available the Settlement Funding, in a total amount not to exceed \$550,400 for the sole purpose of funding Approved Claim Payments. Tivity shall be obligated to advance funds only as needed for the foregoing purposes, and any portion of

the Settlement Funding that is not required to fund Approved Claim Payments will remain with Tivity. Tivity need not segregate funds or create special accounts. In no event shall Tivity's total financial liability with respect to Approved Claim Payments under this Agreement and the Settlement exceed \$550,400.

41. Tivity also agrees to separately pay all Settlement Costs.

**V. Settlement Approval**

42. Upon execution of this Agreement by all Parties, Class Counsel shall promptly move the Court for the entry of the Preliminary Approval Order. The motion for preliminary approval shall request that the Court: (1) preliminarily approve the terms of the Settlement as within the range of fair, adequate and reasonable; (2) provisionally certify the Settlement Class pursuant to Federal Rule of Civil Procedure 23(b)(3) and (e) for settlement purposes only; (3) approve the Notice Program set forth herein and approve the form and content of the Notices of the Settlement; (4) approve the claims process; (5) approve the procedures for members of the Settlement Class to exclude themselves from the Settlement Class or to object to the Settlement; (6) re-open and stay the Action pending Final Approval of the Settlement; and (7) schedule a Final Approval hearing for a time and date mutually convenient for the Court, Class Counsel and counsel for Tivity, at which the Court will conduct an inquiry into the fairness of the Settlement, determine whether it was made in good faith, and determine whether to approve the Settlement and Class Counsel's application for attorneys' fees, costs, and expenses and a Service Award to the Class Representative ("Final Approval Hearing").

**VI. Settlement Administrator**

43. The Settlement Administrator shall administer various aspects of the Settlement as described herein and perform such other functions as are specified elsewhere in this Agreement, including, but not limited to:

- i. obtaining the Fax List from Class Counsel and Tivity;
- ii. performing reverse telephone number look-ups by fax number to determine available associated physical addresses that might exist for any members of the Settlement Class for whom the Parties do not have addresses, and verifying and updating all addresses for members of the Settlement Class included in the Fax List or obtained through the reverse telephone number look-up through the National Change of Address database for the purpose of providing Mailed Notice;
- iii. providing Mailed Notice;
- iv. providing Long Form Notice through the Settlement Website;
- v. establishing and maintaining the Settlement Website;
- vi. establishing and maintaining a post office box for requests for opt-outs from the Settlement Class;
- vii. receiving, evaluating, and processing Claim Forms;
- viii. advising members of the Settlement Class if their Claim Forms are deficient;
- ix. providing weekly reports about the Notice Program and number and identity of opt-outs (if any) to Class Counsel and Tivity Counsel;
- x. establishing and maintaining an automated toll-free telephone line for members of the Settlement Class to call with Settlement-related inquiries and to request a mailed Claim Form;

- xi. responding to any inquiries from members of the Settlement Class;
- xii. processing all opt-out requests from members of the Settlement Class;
- xiii. at Class Counsel's request in advance of the Final Approval Hearing, preparing an affidavit to submit to the Court that identifies each member of the Settlement Class who timely and properly requested exclusion from the Settlement Class;
- xiv. performing the duties described in this Agreement, and any other Settlement-administration-related function at the joint instruction of Class Counsel and Tivity Counsel; and
- xv. distributing Approved Claim Payments to the Settlement Class Members that file Approved Claims, as detailed herein.

**VII. Notice to the Settlement Class**

44. Following the Court's entry of the Preliminary Approval Order, the Settlement Administrator shall implement the Notice Program provided herein, using the forms of Notice approved by the Court in the Preliminary Approval Order. The Notice shall include, among other information: a description of the material terms of the Settlement, including how to file a Claim Form, a date by which members of the Settlement Class may exclude themselves from or "opt-out" of the Settlement Class; a date by which members of the Settlement Class may object to the Settlement; the date upon which the Final Approval Hearing is scheduled to occur; and the address of the Settlement Website at which members of the Settlement Class may access this Agreement and other related documents and information. Class Counsel and Tivity Counsel shall insert the correct dates and deadlines in the Notice before the Notice Program commences, based upon those dates and deadlines set by the Court in the Preliminary Approval Order. Notices and publications provided



under or as part of the Notice Program shall not bear or include the Tivity logo or trademarks or the return address of Tivity, or otherwise be styled to appear to originate from Tivity. Ownership of the Settlement Website URL shall be transferred to Tivity within 10 days of the date on which operation of the Settlement Website ceases, which shall be 3 months following distribution of Approved Claim Payments to Settlement Class Members, or such other date as Class Counsel and Tivity Counsel may agree upon in writing.

45. The Notice shall include a procedure for members of the Settlement Class to opt-out of the Settlement, as detailed below. A member of the Settlement Class may opt-out of the Settlement at any time on or before the Opt-Out and Objection Deadline. Any member of the Settlement Class who does not timely and validly request to opt-out, or who submits a Claim Form, shall be bound by the terms of this Agreement and the Final Approval Order.
46. Members of the Settlement Class who wish to opt-out of and be excluded from the Settlement must submit a written request to opt-out of the Settlement to the Settlement Administrator. To be timely, an opt-out request must be postmarked on or before the Opt-Out and Objection Deadline. The opt-out request must:
  - a. state the member of the Settlement Class's full name (or, if a business, business name), email address, address, telephone number, and fax number at which the Tivity Fax(es) are (were) received;
  - b. state that the member of the Settlement Class requests exclusion from, or "opts-out" of, the Settlement;
  - c. be dated; and
  - d. be signed by the member under penalty of perjury.

Opt-out requests must be made individually and cannot be made on behalf of other members of the Settlement Class. So-called “mass” or “class” opt-outs will not be allowed. If a member of the Settlement Class submits a deficient opt-out, the Settlement Administrator shall notify the member of the deficiency within seven (7) business days of receipt. The member shall have until the later of the Opt-Out and Objection Deadline, or seven (7) business days from receiving notice from the Settlement Administrator of the deficiency, to cure said deficiencies. Members of the Settlement Class submitting untimely or deficient opt-outs shall be bound by the Agreement and its releases. If a member of the Settlement Class submits both a Claim Form and an opt-out, the member of the Settlement Class will be bound by the Agreement and the Final Approval Order.

47. The Notice shall include a procedure for members of the Settlement Class to object to the Settlement and/or to Class Counsel’s application for attorneys’ fees, costs and expenses and/or a Service Award to the Class Representative. Objections to the Settlement, to the application for fees, costs, expenses and/or for the Service Award must be mailed to the Clerk of the Court, Class Counsel, and/or Tivity Counsel. For an objection to be considered by the Court, the objection must be submitted by the Opt-Out and Objection Deadline. If submitted by mail, an objection shall be deemed to have been submitted when posted if received with a postmark date indicated on the envelope, mailed first-class postage prepaid and addressed in accordance with the instructions. If submitted by private courier (*e.g.*, FedEx), an objection shall be deemed to have been submitted on the shipping date reflected on the shipping label.
48. For an objection to be considered by the Court, the objection must also set forth:

- a. the objector's full name (or, if a business, business name), address, telephone number, and fax number at which the Tivity Fax(es) was (were) received;
- b. an explanation of the basis upon which the objector claims to be a member of the Settlement Class;
- c. the grounds for the objection, accompanied by legal support for the objection, if any;
- d. the identity of any counsel who represent the objector, including any former or current counsel who may be entitled to compensation for any reason related to the objection to the Settlement or fee application or who will appear at the Final Approval Hearing; and
- e. the objector's signature (an attorney's signature is not sufficient).

Objections must be made individually and cannot be made on behalf of other members of the Settlement Class.

- 49. Notice shall be provided to Settlement Class Members in two different ways: Mailed Notice and Long-Form Notice on the Settlement Website and to be sent to members of the Settlement Class upon request.
- 50. The Settlement Administrator shall perform reverse fax number look ups to determine available associated mailing addresses that might exist for any members of the Settlement Class for whom the Parties do not have such addresses, shall run addresses through the National Change of Address Database, and shall mail to all members of the Settlement Class postcards that contain details about the Settlement ("Initial Mailed Notice").
- 51. The Settlement Administrator shall perform reasonable address traces for all Initial Mailed Notice postcards that are returned as undeliverable. By way of example, a "reasonable"

tracing procedure would be to run addresses of returned postcards through the Lexis/Nexis database that can be utilized for such purpose. The Settlement Administrator shall complete the re-mailing of Mailed Notice postcards to those members of the Settlement Class whose new addresses were identified as of that time through address traces (“Notice Re-mailing Process”). The Settlement Administrator’s continued efforts in connection with the Notice Re-mailing Process shall not affect or extend the Opt-Out and Objection Deadline.

52. The Mailed Notice Program (which is composed of both the Initial Mailed Notice and the Notice Re-mailing Process) shall be completed no later than 45 days before the Final Approval Hearing. The Settlement Administrator shall provide Class Counsel and Tivity Counsel an affidavit that confirms that the Mailed Notice Program was completed in a timely manner. Class Counsel shall file that affidavit with the Court as an exhibit to or in conjunction with Plaintiff’s motion for Final Approval of the Settlement.
53. Within the parameters set forth in this Agreement, further specific details of the Notice Program shall be subject to the agreement of Class Counsel and Tivity Counsel.

#### **VIII. Final Approval Order and Judgment**

54. The Plaintiff’s motion for preliminary approval of the Settlement will include a request to the Court for a scheduled date on which the Final Approval Hearing will occur, at least 90 days after entry of the Preliminary Approval Order. Plaintiff shall file its motion for Final Approval of the Settlement, and an application for attorneys’ fees, costs and expenses and for a Service Award for the Class Representative, no later than 45 days prior to the Final Approval Hearing. At the Final Approval Hearing, the Court will hear argument on Plaintiff’s Motion for Final Approval of the Settlement, and on Class Counsel’s application

for attorneys' fees, costs, and expenses and for a Service Award for the Class Representative. In the Court's discretion, the Court also will hear argument at the Final Approval Hearing from any members of the Settlement Class (or their counsel) who object to the Settlement or to the fee, cost, expense or Service Award application, provided the objectors submitted timely objections that meet all of the requirements listed in this Agreement.

55. At or following the Final Approval Hearing, the Court will determine whether to enter the Final Approval Order granting Final Approval of the Settlement and entering final judgment thereon, and whether to approve Class Counsel's request for attorneys' fees, costs, expenses, and a Service Award. The proposed Final Approval Order shall, among other things:

- a. Determine that the Settlement is fair, adequate and reasonable;
- b. Finally certify the Settlement Class for settlement purposes only;
- c. Determine that the Notice provided satisfies Due Process requirements;
- d. Enter judgment dismissing the Action with prejudice and without costs, except as set forth in this Agreement;
- e. Bar and enjoin all Releasing Parties from asserting any of the Released Claims, including during any appeal from the Final Approval Order;
- f. Release Tivity and the other Released Parties from the Released Claims; and
- g. Reserve the Court's continuing and exclusive jurisdiction over the Parties to this Agreement, including Tivity, all Settlement Class Members, and all objectors, to administer, supervise, construe and enforce this Agreement in accordance with its terms.

**IX. Settlement Funding & Settlement Costs**

56. In exchange for the mutual promises and covenants in this Agreement, including, without limitation, the Releases and the dismissal of the Action upon Final Approval, Tivity shall make the Settlement Funding available as provided herein. The Settlement Funding shall be used for the sole purpose of paying Approved Claim Payments.
57. Tivity shall also separately pay the following Settlement Costs:
- a. Any Court-ordered award of Class Counsel's attorneys' fees, costs, and expenses;
  - b. Any Court-ordered Service Award to the Class Representative; and
  - c. Settlement notice and administration costs and expenses.

**X. Distribution of Settlement Funding, Disposition of Residual Funds**

58. Within 30 days after the Claims Deadline, the Settlement Administrator shall transmit to Class Counsel and Tivity Counsel a written notice that (a) identifies all of the Claim Forms received by the Settlement Administrator; (b) with respect to each Claim Form, indicates whether the Settlement Administrator has determined that the Claim Form qualifies as an Approved Claim or has rejected the Claim Form; and (c) describes the total amount of funds that is required to pay all Approved Claims. Within 7 business days after the later of: (i) the Effective Date; or (ii) receiving from the Settlement Administrator the foregoing written notice, Tivity shall transmit funds from the Settlement Funding to the Settlement Administrator in an amount that is sufficient to pay all Approved Claims.
59. The Settlement Administrator shall send Settlement Class Members their Approved Claim Payments no later than 14 days after receiving funds from Tivity to pay such Approved Claim.

**XI. Claims Process**

60. Each member of the Settlement Class who does not timely opt-out from the Settlement shall be a Settlement Class Member and entitled to make a Claim. Only one Claim per fax number will be validated and deemed an Approved Claim.
61. To make a claim, members of the Settlement Class must submit by the Claims Deadline a valid and timely Claim Form, a copy of which is attached hereto as Exhibit 3 (and incorporated into the Mailed Notice), by U.S. mail, email, fax, or through the Settlement Website. The Claim Form shall contain the Settlement Class Member's: (1) name; (2) current address; (3) fax number(s) at which she, he, or it received one or more Tivity Faxes; and (4) a current contact telephone number. If a Settlement Class Member fails to fully complete a Claim Form or the fax number does not appear on the Fax List, the Claim Form will be invalid and rejected by the Settlement Administrator. The Settlement Administrator will then attempt to notify the Settlement Class Member that the Claim Form was deficient and rejected. Any Settlement Class Member who submits an incomplete or inaccurate Claim Form shall be permitted to re-submit a Claim Form by the later of the Claims Deadline or 14 days of the sending of notice of the defect by the Settlement Administrator.
62. Approved Claim Payments shall be sent to Settlement Class Members by the Settlement Administrator via U.S. mail. If any Approved Claim Payments are returned, the Settlement Administrator shall attempt to obtain a new mailing address for that Settlement Class Member. If after a second mailing, the Approved Claim Payment is again returned, no further efforts need be taken by the Settlement Administrator to resend the check. Each Approved Claim Payment will be negotiable for 180 days after it is issued. All funds

associated with uncashed Approved Claim Payments shall be escheated to the appropriate state authority.

XII. **Releases**

63. The Parties intend that this Settlement Agreement will fully and finally dispose of the Action and any and all Released Claims against the Released Parties.
64. On the Effective Date, the Releasing Parties, and each of them, shall be deemed to have, and by operation of the Final Approval Order shall have, fully, finally, and forever released, relinquished, and discharged all Released Claims against the Released Parties, and each of them.
65. On the Effective Date, the Releasing Parties, and each of them, will be forever barred and permanently enjoined from directly, indirectly, representatively or in any other capacity, filing, commencing, prosecuting, continuing, litigating, intervening in, participating in as class members or otherwise, or receiving any benefits or other relief from any lawsuit, any arbitration, or any administrative, regulatory, or other proceeding against any of the Released Parties in any jurisdiction based on or relating in any way to the Released Claims, and the Releasing Parties, and each of them, shall be forever barred and permanently enjoined from filing, commencing, or prosecuting any lawsuit individually or as a class action against any of the Released Parties (including by seeking to amend a pending complaint to include class allegations or by seeking class certification in a pending action in any jurisdiction) based on or relating in any way to the Released Claims on behalf of members of the Settlement Class who have not timely excluded themselves from the Settlement Class.



**XIII. Payment of Attorneys' Fees, Expenses, and Service Awards**

66. Class Counsel will request that the Court approve an award of attorneys' fees and reimbursement of documented costs and expenses. Tivity fully reserves its rights to oppose any such request, in whole or in part. Any award of attorneys' fees, costs, and expenses to Class Counsel by the Court (together, the "Fee Award") shall be payable by Tivity. The Parties agree that the Court's failure to approve, in whole or in part, any award of attorneys' fees and expenses shall not prevent the Settlement from becoming effective, nor shall it be grounds for termination. Tivity shall pay the Fee Award to Class Counsel within seven (7) business days after the later of the following: (i) the Effective Date; or (ii) the date on which all appellate rights with respect to such Fee Award have expired or have been exhausted in such a manner as to affirm the Fee Award, and when no further appeals are possible with respect to the Fee Award.
67. Class Counsel will also ask the Court to approve a Service Award to the Class Representative. Tivity fully reserves its rights to oppose any such request, in whole or in part. The Service Award is to be paid by Tivity. The Service Award shall be paid to the Class Representative in addition to any Approved Claim Payment owed to the Class Representative. The Parties agree that the Court's failure to approve, in whole or in part, a Service Award shall not prevent the Settlement from becoming effective, nor shall it be grounds for termination. Tivity shall pay the Service Award, if any, to the Class Representative, by transmitting funds to Class Counsel, within seven (7) business days after the Effective Date.

**XIV. Termination of Settlement**

68. This Settlement may be terminated by either Class Counsel or Tivity by serving on counsel for the opposing Party and filing with the Court a written notice of termination within 30 days (or such longer time as may be agreed in writing between Class Counsel and Tivity) after any of the following occurrences:
- a. Class Counsel and Tivity agree to termination;
  - b. the Court does not preliminarily approve the Settlement within 180 days after filing of the motion for preliminary approval, or does not finally approve the Settlement within 360 days of Preliminary Approval by the Court;
  - c. the Court rejects, materially modifies, materially amends or changes the Settlement;
  - d. an appellate court vacates or reverses the Final Approval Order, and the Settlement is not reinstated and finally approved without material change by the Court on remand within 270 days of such reversal;
  - e. any court incorporates into, or deletes or strikes from, or modifies, amends, or changes, the Preliminary Approval Order, Final Approval Order, or the Settlement in a way that the Party seeking to terminate the Settlement reasonably considers material;
  - f. the Effective Date does not occur;
  - g. If, prior to the Final Approval Hearing, the number of members of the Settlement Class who have timely submitted requests for exclusion from the Settlement Class in accordance with the provisions of the Preliminary Approval Order and the Notice given pursuant thereto exceeds 10 percent of the number of fax numbers included in the Fax List, Tivity shall have, in its sole and absolute discretion, the option to

terminate this Agreement. Tivity may terminate the Agreement by filing a Termination Notice with the Court and serving such Termination Notice on Class Counsel by hand delivery or overnight courier within ten (10) business days after being informed in writing by the Settlement Administrator that requests for exclusion have been timely filed in a number that exceeds 10 percent of the number of fax numbers in the Fax List; or

h. any other ground for termination provided for elsewhere in this Agreement.

**XV. Effect of a Termination**

69. In the event of a termination, this Agreement shall be considered null and void; all of Plaintiff's, Class Counsel's, and Tivity's obligations under the Settlement shall cease to be of any force and effect; and the Parties shall return to the status *quo ante* in the Action as if the Parties had not entered into this Agreement. In addition, in the event of such a termination, all of the Parties' respective pre-Settlement rights, claims and defenses will be retained and preserved.

70. The Settlement shall become effective on the Effective Date unless earlier terminated.

71. In the event the Settlement is terminated, any discussions, offers, or negotiations associated with this Settlement shall not be discoverable or offered into evidence or used in the Action or any other action or proceeding for any purpose. In such event, all Parties to the Action shall stand in the same position as if this Agreement had not been negotiated, made or filed with the Court.

**XVI. No Admission of Liability; Non-Disparagement**

72. Tivity continues to dispute its liability for the claims alleged in the Action and further disputes class treatment, and maintains that it has complied, at all times, with applicable

laws and regulations. Tivity not by this Agreement or otherwise admit any liability or wrongdoing of any kind. Tivity has agreed to enter into this Agreement to avoid the further expense, inconvenience, and distraction of burdensome and protracted litigation, and to be completely free of any further claims that were asserted or could have been asserted in the Action.

73. Class Counsel believes that the claims asserted in the Action have merit, and they have examined and considered the benefits to be obtained under the proposed Settlement set forth in this Agreement, the risks associated with the continued prosecution of this complex, costly and time-consuming litigation, and the likelihood of success on the merits of the Action. Class Counsel fully investigated the facts and law relevant to the merits of the claims, and conducted extensive discovery.
74. Class Counsel concluded that the proposed Settlement set forth in this Agreement is fair, adequate, reasonable, and in the best interests of the Settlement Class.
75. The Parties understand and acknowledge that this Agreement constitutes a compromise and settlement of disputed claims. No action taken by the Parties either previously or in connection with the negotiations or proceedings connected with this Agreement shall be deemed or construed to be an admission of the truth or falsity of any claims or defenses heretofore made, or an acknowledgment or admission by any party of any fault, liability or wrongdoing of any kind whatsoever.
76. Neither the Settlement, nor any act performed or document executed pursuant to or in furtherance of the Settlement: (a) is or may be deemed to be, or may be used as, an admission of, or evidence of, the validity of any claim made by the Plaintiff or Settlement Class Members, or of any wrongdoing or liability of the Released Parties; or (b) is or may

be deemed to be, or may be used as, an admission of, or evidence of, any fault or omission of any of the Released Parties, in the Action or in any proceeding in any court, administrative agency or other tribunal.

77. In addition to any other defenses Tivity may have at law, in equity, or otherwise, to the extent permitted by law, this Agreement may be pleaded as a full and complete defense to, and may be used as the basis for an injunction against, any action, suit or other proceeding that may be instituted, prosecuted or attempted in breach of this Agreement or the Releases contained herein.

**XVII. Miscellaneous Provisions**

78. Gender and Plurals. As used in this Agreement, the masculine, feminine or neuter gender, and the singular or plural number, shall each be deemed to include the others whenever the context so indicates.
79. Binding Effect. This Agreement shall be binding upon, and inure to the benefit of, the successors and assigns of the Releasing Parties and the Released Parties.
80. Cooperation of Parties. The Parties to this Agreement agree to cooperate in good faith to prepare and execute all documents, to seek Court approval, uphold Court approval, and do all things reasonably necessary to complete and effectuate the Settlement described in this Agreement. This obligation of the Parties to support and complete the Settlement shall remain in full force and effect regardless of events that may occur.
81. Obligation To Meet And Confer. Before filing any motion in the Court raising a dispute arising out of or related to this Agreement, the Parties shall consult with each other and certify to the Court that they have consulted.

82. Integration. This Agreement constitutes a single, integrated written contract expressing the entire agreement of the Parties relative to the subject matter hereof. No covenants, agreements, representations, or warranties of any kind whatsoever have been made by any Party hereto, except as provided for herein.
83. No Conflict Intended. Any inconsistency between the headings used in this Agreement and the text of the paragraphs of this Agreement shall be resolved in favor of the text.
84. Governing Law. Except as otherwise provided herein, the Agreement shall be construed in accordance with, and be governed by, the laws of the State of New York, without regard to the principles thereof regarding choice of law.
85. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, even though all Parties do not sign the same counterparts. Original signatures are not required. Any signature submitted by facsimile or through email of an Adobe PDF shall be deemed an original.
86. Jurisdiction. The Court shall retain jurisdiction over the implementation, enforcement, and performance of this Agreement, and shall have exclusive jurisdiction over any suit, action, proceeding or dispute arising out of or relating to this Agreement that cannot be resolved by negotiation and agreement by counsel for the Parties. The Court shall retain jurisdiction with respect to the administration, consummation and enforcement of the Agreement and shall retain jurisdiction for the purpose of enforcing all terms of the Agreement. The Court shall also retain jurisdiction over all questions and/or disputes related to the Notice program and the Settlement Administrator. As part of their respective agreements to render services

in connection with this Settlement, the Settlement Administrator shall consent to the jurisdiction of the Court for this purpose.

87. Notices. All notices to Class Counsel provided for herein shall be sent by email with a hard copy sent by overnight mail to:

Avi R. Kaufman  
KAUFMAN P.A.  
400 NW 26<sup>th</sup> Street  
Miami, FL 33127  
Email: kaufman@kaufmanpa.com

All notices to Tivity provided for herein shall be sent by email with a hard copy sent by overnight mail to:

David Layden  
JENNER & BLOCK LLP  
353 N. Clark Street  
Chicago, IL 60654  
Email: dlayden@jenner.com

The notice recipients and addresses designated above may be changed by written notice.

The Parties agree to promptly provide each other with copies of objections, opt outs, or other filings received as a result of the Notice program.

88. Modification and Amendment. This Agreement may not be amended or modified, except by a written instrument signed by Class Counsel and counsel for Tivity and, if the Settlement has been approved preliminarily by the Court, approved by the Court.
89. No Waiver. The waiver by any Party of any breach of this Agreement by another Party shall not be deemed or construed as a waiver of any other breach, whether prior, subsequent, or contemporaneous, of this Agreement.
90. Authority. Class Counsel (for the Plaintiff and the Settlement Class Members), and counsel for Tivity (for Tivity), represent and warrant that the persons signing this Agreement on

their behalf have full power and authority to bind every person, partnership, corporation or entity included within the definitions of Plaintiff and Tivity to all terms of this Agreement. Any person executing this Agreement in a representative capacity represents and warrants that he or she is fully authorized to do so and to bind the Party on whose behalf he or she signs this Agreement to all the terms and provisions of this Agreement.

91. Agreement Mutually Prepared. Neither Tivity nor Plaintiff, nor any of them, shall be considered to be the drafter of this Agreement or any of its provisions for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter of this Agreement.
92. Independent Investigation and Decision to Settle. The Parties understand and acknowledge that they: (a) have performed an independent investigation of the allegations of fact and law made in connection with this Action; and (b) that even if they may hereafter discover facts in addition to, or different from, those that they now know or believe to be true with respect to the subject matter of the Action as reflected in this Agreement, that will not affect or in any respect limit the binding nature of this Agreement. Tivity has provided and is providing information that Plaintiff reasonably requests to identify the members of the Settlement Class. It is the Parties' intention to resolve their disputes in connection with this Action pursuant to the terms of this Agreement now and thus, in furtherance of their intentions, the Agreement shall remain in full force and effect notwithstanding the discovery of any additional facts or law, or changes in law, and this Agreement shall not be subject to rescission or modification by reason of any changes or differences in facts or law, subsequently occurring or otherwise.



93. Receipt of Advice of Counsel. Each Party acknowledges, agrees, and specifically warrants that he, she or it has fully read this Agreement and the Release, received independent legal advice with respect to the advisability of entering into this Agreement and the Release and the legal effects of this Agreement and the Release, and fully understands the effect of this Agreement and the Release.

Date: Mar 6, 2020

Thomas Taylor  
Thomas Taylor (Mar 6, 2020)

Lackawanna Chiropractic P.C.

*Plaintiff*

By: Dr. Thomas J. Taylor

Its: President

Dated: March 6, 2020



Avi P. Kaufman

*Class Counsel*

Dated: \_\_\_\_\_

Tivity Health Support, LLC

*Defendant*

By:

Its:

Dated: \_\_\_\_\_

David C. Layden

Counsel for Tivity Health Support, LLC

Date: \_\_\_\_\_

\_\_\_\_\_  
Lackawanna Chiropractic P.C.

*Plaintiff*

By: Dr. Thomas J. Taylor


Its: President

Dated: \_\_\_\_\_

\_\_\_\_\_  
Avi R. Kaufman

*Class Counsel*

Dated: \_\_\_\_\_

  
\_\_\_\_\_  
Tivity Health Support, LLC

*Defendant*

By: *Raymond Bilbro*

Its: *Deputy General Counsel*

Dated: \_\_\_\_\_

  
\_\_\_\_\_  
David C. Layden

Counsel for Tivity Health Support, LLC

# EXHIBIT 1

**DRAFT MAILED NOTICE**

**[NOTE: CLAIM FORM TO BE INCLUDED AS PART OF MAILED NOTICE]**

**UNITED STATES DISTRICT COURT FOR  
THE WESTERN DISTRICT OF NEW YORK**

**If You Received a Fax from Tivity Health Solutions, LLC,  
You May Be Entitled to a Payment from a Class Action Settlement.**

*A court authorized this notice. You are not being sued. This is not a solicitation from a lawyer.*

A Settlement has been reached in a class action lawsuit about whether Tivity Health Solutions, LLC (“Tivity”) faxed advertisements without the prior express invitation or permission of the recipients in violation of the Telephone Consumer Protection Act, 47 U.S.C. § 227 (“TCPA”). The TCPA provides for damages of \$500 per violation, which can be increased to as much as \$1,500 per violation if a Court finds that the violation is willful or knowing. Tivity denies the allegations in the lawsuit and the Court has not decided who is right.

**Who’s Included?** You received this notice because Tivity’s records show that you may be a Settlement Class member. The Settlement includes all individuals and entities within the United States who were sent a fax by or on behalf of Tivity recruiting a provider offering chiropractic services, physical therapy, occupational therapy, speech therapy, acupuncture, massage, and/or complementary and alternative medicine (CAM) services to join a Tivity network.

**What are the Settlement Terms?** Tivity has agreed to make Settlement Funding available in an amount up to a total of \$550,400. The Settlement Funding will be used for the sole purpose of funding Approved Claims. Members of the Settlement Class who submit claims that are determined to be Approved Claims shall each receive a cash payment of \$320.00. Only Approved Claims will be paid. Only one claim per fax number will be validated and deemed an Approved Claim. Tivity has agreed to separately pay the fees and expenses of the Settlement Administrator, the attorneys’ fees and costs, if any, awarded to Class Counsel by the Court, and the Service Award to the Class Representative, if any, approved by the Court.

**How can I get a Payment?** By completing the Claim Form attached to this notice and submitting it by U.S. mail to the Settlement Administrator at the address below, by email to [xxxx@THSRecruitingFaxTCPAsettlement.com](mailto:xxxx@THSRecruitingFaxTCPAsettlement.com), or by fax to xxx-xxx-xxxx. You may download or file a Claim Form online at [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com). If you send in a Claim Form by regular mail, it must be postmarked on or before **Month DD, 2020**. The deadline to file a Claim Form online, by email, or by fax is **11:59 p.m. EDT on Month DD, 2020**.

**What are my Other Options?** If you do not want to be legally bound by the Settlement, you must exclude yourself by **Month DD, 2020**. If you do not exclude yourself, you will release any claims you may have, as more fully described in the Settlement Agreement, available at the settlement website. You may object to the Settlement by **Month DD, 2020** by timely and strictly complying with the objection procedures detailed in the Settlement. The Court will hold a Final Approval Hearing on **Month DD, 2020** to consider whether to approve the Settlement and a request for attorneys’ fees not to exceed \$275,200 and reimbursement of documented expenses not to exceed \$15,000, and a Service Award of \$5,000 to the Class Representative. You may appear at the hearing, either yourself or through an attorney hired by you, but you don't have to. For more information visit the website below.

**Tivity Settlement Administrator**

**[ADDRESS]**

**[www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com)**

# EXHIBIT 2

**DRAFT LONGFORM NOTICE****UNITED STATES DISTRICT COURT FOR  
THE WESTERN DISTRICT OF NEW YORK****If You Received a Fax from Tivity Health Solutions, LLC, You May Be Entitled to a Payment from a Class Action Settlement.**

*A federal court authorized this notice. You are not being sued. This is not a solicitation from a lawyer*

- A Settlement<sup>1</sup> has been reached in a class action lawsuit about whether Tivity Health Solutions, LLC (“Tivity”) faxed advertisements without the prior express invitation or permission of the recipients in violation of the Telephone Consumer Protection Act, 47 U.S.C. § 227 (“TCPA”). Tivity denies the allegations in the lawsuit and the Court has not decided who is right.
- The Settlement offers payments to Settlement Class Members who file claims that the Settlement Administrator determines are Approved Claims.
- Your legal rights are affected whether you act or do not act. Read this notice carefully.

<b>YOUR LEGAL RIGHTS AND OPTIONS IN THIS SETTLEMENT:</b>	
<b>SUBMIT A CLAIM FORM</b>	If you are a member of the Settlement Class, you must submit a completed Claim Form to receive a payment. If the Court approves the Settlement and it becomes final and effective, and the Settlement Administrator approves your claim, you will receive a payment by check.
<b>EXCLUDE YOURSELF</b>	You may request to be excluded from the Settlement and if you do, you will receive no benefits from the Settlement.
<b>OBJECT</b>	Write to the Court if you do not like the Settlement.
<b>GO TO A HEARING</b>	Ask to speak in Court about the fairness of the Settlement.
<b>DO NOTHING</b>	You will not receive a payment if you fail to timely submit a completed Claim Form, and you will give up your rights to bring your own lawsuit against Tivity and the other Released Parties arising from the faxes at issue.

- These rights and options—**and the deadlines to exercise them**—are explained in this notice.
- The Court in charge of this case still has to decide whether to approve the Settlement. If it does, and after any appeals are resolved, benefits will be distributed to those who submit qualifying Claim Forms. Please be patient.

<sup>1</sup> Capitalized terms herein have the same meanings as those defined in the Settlement Agreement, a copy of which may be found online at the website below.

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**BASIC INFORMATION**  
**QUESTIONS? CALL 1-8XX-XXX-XXXX OR VISIT**  
**[www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com)**



**1. Why is there a notice?**

A Court authorized this notice because you have a right to know about a proposed Settlement of a class action lawsuit known as *Lackawanna Chiropractic P.C., individually and on behalf of all others similarly situated, v. Tivity Health Support, LLC*, W.D.N.Y. Case No. 1:18-cv-00649-LJV-JJM, and about all of your options before the Court decides whether to give Final Approval to the Settlement. This notice explains the lawsuit, the Settlement, and your legal rights.

Judge Lawrence J. Vilardo of the United States District Court, Western District of New York is overseeing this case. The company that sued, Lackawanna Chiropractic P.C., is called the “Plaintiff.” Tivity Health Solutions, LLC or Tivity is called the “Defendant.”

**2. What is this litigation about?**

The lawsuit alleges that Tivity faxed an advertisement to Plaintiff’s fax machine without Plaintiff’s prior express invitation or permission in violation of the Telephone Consumer Protection Act, 47 U.S.C. § 227 (“TCPA”); and seeks actual and/or statutory damages under the TCPA on behalf of the named Plaintiff and a class of all similarly situated individuals in the United States.

Tivity denies each and every allegation of wrongdoing, liability and damages that were or could have been asserted in the litigation, and that the claims in the litigation would be appropriate for class treatment if the litigation were to proceed through trial.

The Plaintiff’s Amended Complaint, Settlement Agreement and other case-related documents are posted on the website, [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com). The Settlement resolves the lawsuit. The Court has not decided who is right.

**3. What is the Telephone Consumer Protection Act?**

The Telephone Consumer Protection Act (commonly referred to as the “TCPA”) is a federal law that restricts unsolicited fax advertisements. The Plaintiff here alleged that Tivity faxed advertisements to entities and individuals without prior express permission or invitation in violation of the TCPA. The TCPA provides for damages of \$500 per violation, which can be increased to up to \$1,500 per violation if a court finds that the violation is willful or knowing.

**4. Why is this a class action?**

In a class action, one person or entity, called the “Class Representative” (in this case, Plaintiff Lackawanna Chiropractic P.C.), sues on behalf of itself and other people with similar claims.

All of the people and entities that have claims similar to the Plaintiff’s are members of the Settlement Class, except for those who exclude themselves from the class.

**5. Why is there a settlement?**

The Court has not found in favor of either Plaintiff or Tivity. Instead, both sides have agreed to a Settlement. By agreeing to the Settlement, the parties avoid the costs and uncertainty of a trial, and if the Settlement is approved by the Court, members of the Settlement Class that submit claims that are determined to be Approved Claims will receive the benefits described in this notice. Tivity denies all legal claims in this case, but is settling to avoid the uncertainties and costs attendant with litigation. Plaintiff and its lawyers think the proposed Settlement is best for everyone who is affected.

**QUESTIONS? CALL 1-8XX-XXX-XXXX OR VISIT  
[www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com)**

## WHO IS PART OF THE SETTLEMENT

### 6. Who is included in the Settlement?

The Settlement Class includes: All individuals and entities within the United States who were sent a Tivity Fax by or on behalf of Tivity recruiting a provider offering chiropractic services, physical therapy, occupational therapy, speech therapy, acupuncture, massage, and/or complementary and alternative medicine (CAM) services to join a Tivity network.

Excluded from the Settlement Class are (1) the trial judge presiding over this case; (2) Tivity, as well as any parent, subsidiary, affiliate or control person of Tivity, and the officers, directors, agents, servants or employees of Tivity; (3) any of the Released Parties; (4) the immediate family of any such person(s); (5) any member of the Settlement Class who has timely opted out of the Settlement; and (6) Class Counsel and their employees.

### 7. What if I am not sure whether I am included in the Settlement?

If you are not sure whether you are in the Settlement Class, or have any other questions about the Settlement, visit the settlement website at [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com). You also may send questions to the Settlement Administrator at Tivity Settlement Administrator, PO Box XXXX, City, State XXXXX-XXXX or at [xxxx@THSRecruitingFaxTCPAsettlement.com](mailto:xxxx@THSRecruitingFaxTCPAsettlement.com).

## THE SETTLEMENT BENEFITS

### 8. What does the Settlement provide?

Tivity has agreed to make up to \$550,400 available for Settlement Funding. The Settlement Funding will be used for the sole purpose of paying Approved Claim Payments. Members of the Settlement Class who submit claims that the Settlement Administrator determines to be Approved Claims shall each receive \$320.00. Only Approved Claims will be paid. Only one claim per fax number will be validated and deemed an Approved Claim.

### 9. How do I file a Claim?

If you qualify for a cash payment you must complete and submit a valid Claim Form. You can file your Claim Form online at [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com), email it to [xxxx@THSRecruitingFaxTCPAsettlement.com](mailto:xxxx@THSRecruitingFaxTCPAsettlement.com), fax it to xxx-xxx-xxxx, or send it by U.S. Mail to the address below. The deadline to file a Claim Form online, by email, or by fax is **11:59 p.m. EDT on Month Day, 2020**.

Claim Forms submitted by mail must be postmarked on or before **Month Day, 2020** to:

Tivity Settlement Administrator  
PO Box XXX  
City, State XXXXX-XXXX

No matter which method you choose to file your Claim Form, please read the Claim Form carefully and provide all the information required. Only one claim per fax number will be validated and deemed an Approved Claim.

**QUESTIONS? CALL 1-8XX-XXX-XXXX OR VISIT  
[www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com)**

**10. When will I receive my payment?**

Payments to Settlement Class Members that make Approved Claims will be made only after the Court grants Final Approval to the Settlement and after any appeals are resolved (*see* “Final Approval Hearing” below). If there are appeals, resolving them can take time. Please be patient.

**EXCLUDING YOURSELF FROM THE SETTLEMENT**

If you do not want benefits from the Settlement, and you want to keep the right to sue or continue to sue Tivity on your own about the legal issues in this case, then you must take steps to get out of the Settlement. This is called excluding yourself – or it is sometimes referred to as “opting-out” of the Settlement Class.

**11. How do I get out of the Settlement?**

To exclude yourself from the Settlement, you must send a timely letter by mail to:

Tivity Settlement Administrator  
PO Box XXXX  
City, State XXXXX-XXXX

Your request to be excluded from the Settlement must be personally signed by you under penalty of perjury, be dated, include your full name (or, if a business, business name), email address, telephone number, and fax number at which the Tivity Fax(es) was (were) received, and contain a statement that indicates your desire to be “excluded from the Settlement Class.” Absent excluding yourself or “opting-out” you are otherwise a member of the Settlement Class.

Your exclusion request must be postmarked no later than **Month Day, 2020**. You cannot ask to be excluded on the phone, by email, or at the website. Opt outs must be made individually and cannot be made on behalf of other members of the Settlement Class.

**12. If I do not exclude myself, can I sue the Defendant for the same thing later?**

No. Unless you exclude yourself, you give up the right to sue Tivity or any of the Released Parties for the claims that the Settlement resolves. You must exclude yourself from this Settlement to pursue your own lawsuit.

**13. What am I giving up to stay in the Settlement Class?**

Unless you opt-out of the Settlement, you cannot sue or be part of any other lawsuit against Tivity or any of the Released Parties about the issues in this case, including any existing litigation, arbitration, or proceeding. Unless you exclude yourself, all of the decisions and judgments by the Court will bind you.

The Settlement Agreement is available at [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com). The Settlement Agreement provides more detail regarding the Releases and describes the Released Claims with specific descriptions in necessary, accurate legal terminology, so read it carefully. You can talk to the law firm representing the Class (Class Counsel) listed in Question 15 for free or you can, at your own

**QUESTIONS? CALL 1-8XX-XXX-XXXX OR VISIT  
[www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com)**

expense, talk to your own lawyer if you have any questions about the Released Claims or what they mean.

**14. If I exclude myself, can I still get a payment?**

No. You will not get a payment from the Settlement Fund if you exclude yourself from the Settlement.

**THE LAWYERS REPRESENTING YOU**

**15. Do I have a lawyer in the case?**

The Court has appointed Avi R. Kaufman of Kaufman P.A. and Stefan Coleman of Law Offices of Stefan Coleman, P.A. as “Class Counsel” to represent all members of the Settlement Class. You will not be charged for these lawyers. If you want to be represented by another lawyer, you may hire one to appear in Court for you at your own expense.

**16. How will the lawyers be paid?**

Class Counsel intend to request attorneys’ fees in an amount not to exceed \$275,200, plus reimbursement of out-of-pocket expenses incurred in the litigation up to \$15,000. The fees and expenses awarded by the Court will be paid by Tivity and will not come from the Settlement Funding. The Court will decide the amount of fees and expenses to award.

Class Counsel also will request that a Service Award not to exceed \$5,000.00 be paid by Tivity, which will not come from the Settlement Funding, to the Class Representative for its service as representative on behalf of the whole Settlement Class.

**OBJECTING TO THE SETTLEMENT**

**17. How do I tell the Court if I do not like the Settlement?**

If you are a member of the Settlement Class (and do not exclude yourself from the Settlement Class), you can object to any part of the Settlement. To object, you must timely submit a letter that includes the following:

- 1) A heading that includes the case name and case number – *Lackawanna Chiropractic P.C. v. Tivity Health Support, LLC, W.D.N.Y. Case No. 1:18-cv-00649-LJV-JJM*.
- 2) Your name (or, if a business, business name), address, telephone number, the fax number at which you received one or more fax advertisements sent by or on behalf of Tivity and, if represented by counsel, the name, bar number, address and telephone number of your counsel;
- 3) A signed statement stating, under penalty of perjury, explaining the basis upon which you believe to be a member of the Settlement Class;
- 4) A statement of all your objections to the Settlement including your legal and factual basis, if any, for each objection;
- 5)

If you wish to object, you must mail your objection to each of the following three (3) addresses, and your objection must be postmarked by **Month Day, 2020**:

<b>Clerk of the Court</b>	<b>Class Counsel</b>	<b>Defendant’s Counsel</b>
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**QUESTIONS? CALL 1-8XX-XXX-XXXX OR VISIT  
www.THSRecruitingFaxTCPAsettlement.com**

Clerk of Court United States District Court Western District of New York 2 Niagara Square Buffalo, NY 14202-3498	Avi R. Kaufman KAUFMAN P.A. 400 NW 26 <sup>th</sup> Street Miami, Florida 33127	David Layden JENNER & BLOCK LLP 353 N. Clark Street Chicago, IL 60654
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#### 18. What is the difference between objecting and asking to be excluded?

Objecting is telling the Court that you do not like something about the Settlement. You can object to the Settlement only if you do not exclude yourself. Excluding yourself is telling the Court that you do not want to be part of the Settlement. If you exclude yourself, you have no basis to object to the Settlement because it no longer affects you.

### THE FINAL APPROVAL HEARING

The Court will hold a hearing to decide whether to approve the Settlement and any requests for fees expenses, and a Service Award (“Final Approval Hearing”).

#### 19. When and where will the Court decide whether to approve the settlement?

The Court has scheduled a Final Approval Hearing on **Month Day, 2020 at \_\_:\_\_\_\_\_m**, at the \_\_\_\_\_. The hearing may be moved to a different date or time without additional notice, so it is a good idea to check [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com) for updates. At this hearing, the Court will consider whether the Settlement is fair, reasonable, and adequate. The Court will also consider the requests by Class Counsel for attorneys’ fees and expenses and for a Service Award to the Class Representative. If there are objections, the Court will consider them at that time. After the hearing, the Court will decide whether to approve the Settlement. It is unknown how long these decisions will take.

**20. Do I have to attend the hearing?**

No. Class Counsel will answer any questions the Court may have. You are welcome to attend the hearing at your own expense.

**21. May I speak at the hearing?**

If you attend the Final Approval Hearing, you may ask the Court for permission to speak if you so choose. However, you cannot speak at the hearing if you exclude yourself from the Settlement.

**IF YOU DO NOTHING**

**22. What happens if I do nothing at all?**

If you are a member of the Settlement Class and do nothing, meaning you do not file a timely Claim Form, you will not get benefits from the Settlement. Further, unless you exclude yourself, you will be bound by the judgment entered by the Court.

**GETTING MORE INFORMATION**

**23. How do I get more information?**

This notice summarizes the proposed Settlement. You are urged to review more details in the Settlement Agreement. For a complete, definitive statement of the Settlement terms, refer to the Settlement Agreement at [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com). You also may write with questions to Class Counsel at the address above or the Settlement Administrator at Tivity Settlement Administrator, PO Box XXXX, City, State XXXXX-XXXX, or at [xxxx@THSRecruitingFaxTCPAsettlement.com](mailto:xxxx@THSRecruitingFaxTCPAsettlement.com).

# EXHIBIT 3

**DRAFT CLAIM FORM**  
**[NOTE: CLAIM FORM TO BE INCLUDED AS ATTACHMENT**  
**TO MAILED NOTICE]**

To submit a claim for a payment from the Settlement Funding, please fill out the Claim Form below and submit it by U.S. mail at the address below, by email to [xxxx@THSRecruitingFaxTCPAsettlement.com](mailto:xxxx@THSRecruitingFaxTCPAsettlement.com), or by fax to xxx-xxx-xxxx. You may also file a Claim Form online at [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com). The deadline to file a Claim Form online, by email, or by fax is 11:59 p.m. EDT on Month DD, 2020. If you send in a Claim Form by regular mail, it must be postmarked on or before Month DD, 2020.

\*Name (First Name / MI / Last Name)

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\*Business Name (if applicable)

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\*Mailing Address

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\*Fax Number that received one or more faxes from Tivity:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Telephone Number where you can be reached:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Email Address:

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\*I declare under penalty of perjury that to the best of my knowledge I received one (1) or more faxes recruiting an individual or entity to join a Tivity network.

\*Signature: \_\_\_\_\_

\*Date: \_\_\_\_\_

**\*DENOTES INFORMATION YOU MUST PROVIDE TO HAVE A VALID CLAIM**

Questions? Visit [www.THSRecruitingFaxTCPAsettlement.com](http://www.THSRecruitingFaxTCPAsettlement.com) or email [xxxx@THSRecruitingFaxTCPAsettlement.com](mailto:xxxx@THSRecruitingFaxTCPAsettlement.com).

To submit by U.S. Mail send to:  
**Tivity Settlement Administrator**  
**[ADDRESS]**



# EXHIBIT 4

**IN THE UNITED STATES DISTRICT COURT  
THE WESTERN DISTRICT OF NEW YORK**

**LACKAWANNA CHIROPRACTIC P.C.**, a  
New York professional corporation,  
individually and on behalf of all others  
similarly situated,

*Plaintiff,*

*v.*

**TIVITY HEALTH SUPPORT, LLC**, a  
Delaware limited liability company,

*Defendant.*

**Case No. 1:18-cv-00649-LJV**

**CLASS ACTION**

**[PROPOSED] ORDER PRELIMINARILY APPROVING  
CLASS ACTION SETTLEMENT AND CERTIFYING THE SETTLEMENT CLASS**

Plaintiff Lackawanna Chiropractic P.C., on behalf of itself and a class of similarly situated persons, and Defendant Tivity Health Support, LLC (referred to as “Tivity” or “Defendant”), have agreed to settle this Action pursuant to the terms and conditions set forth in an executed Settlement Agreement dated as of March 6, 2020 (“Settlement Agreement” or “Agreement”). The Parties reached the Settlement through arm’s-length negotiations. Under the Settlement, subject to the terms and conditions therein and subject to Court approval, Plaintiff and the other Releasing Parties will fully, finally, and forever resolve, discharge, and release the Released Claims against the Released Parties.

The Settlement has been filed with the Court, and Plaintiff and Class Counsel have filed a Motion for Preliminary Approval of Modified Class Action Settlement (“Motion”). Upon considering the Motion, the Settlement and all exhibits thereto, the record in these proceedings, the representations and recommendations of counsel, and the requirements of law, the Court finds that: (1) this Court has jurisdiction over the subject matter and the Parties to this Action; (2) the

proposed Settlement Class meets the requirements of Federal Rule of Civil Procedure 23 and should be certified for settlement purposes only; (3) the persons and entities identified below should be appointed Class Representative and Class Counsel; (4) the Settlement is the result of informed, good-faith, arm's-length negotiations between the Parties and their capable and experienced counsel, and is not the result of collusion; (5) the Settlement is within the range of reasonableness and should be preliminarily approved; (6) the proposed Notice Program and proposed forms of Notice satisfy Federal Rule of Civil Procedure 23 and constitutional due process requirements, and are reasonably calculated under the circumstances to apprise the Settlement Class of the pendency of the Action, class certification, terms of the Settlement, Class Counsel's application for an award of attorneys' fees and expenses ("Fee Application") and request for a Service Award for Plaintiff, and their rights to opt-out of the Settlement Class or object to the Settlement, Class Counsel's Fee Application, and/or the request for a Service Award for Plaintiff; (7) good cause exists to re-open and stay the Action pending Final Approval of the Settlement; (8) good cause exists to schedule and conduct a Final Approval Hearing, pursuant to Federal Rule of Civil Procedure 23(e), to assist the Court in determining whether to grant Final Approval of the Settlement and enter the Final Approval Order, and whether to grant Class Counsel's Fee Application and request for a Service Award for Plaintiff; and (9) the other related matters pertinent to the Preliminary Approval of the Settlement should also be approved.

Based on the foregoing, IT IS HEREBY ORDERED AND ADJUDGED as follows:

1. As used in this Preliminary Approval Order, unless otherwise noted, capitalized terms shall have the definitions and meanings accorded to them in the Settlement.
2. The Court has jurisdiction over the subject matter and Parties to this proceeding pursuant to 28 U.S.C. §§ 1331, 1332.

3. Venue is proper in this District.

Provisional Class Certification and Appointment of Class Representative and Class Counsel

4. It is well established that “[T]he ‘settlement only’ class has become a stock device in modern class action litigation.” *In re American International Group, Inc. Securities Litigation*, 689 F.3d 229, 238 (2d Cir. 2012). In deciding whether to provisionally certify a settlement class, a court must consider the same factors that it would consider in connection with a proposed litigation class – i.e., all Rule 23(a) factors and at least one subsection of Rule 23(b) must be satisfied – except that the Court need not consider the manageability of a potential trial, since the settlement, if approved, would obviate the need for a trial. *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 620 (1997).

5. The Court finds, for settlement purposes, that the Federal Rule of Civil Procedure 23 factors are present and that certification of the proposed Settlement Class is appropriate under Rule 23. The Court therefore provisionally certifies the following Settlement Class.

All individuals and entities within the United States who were sent a Tivity Fax by or on behalf of Tivity recruiting a provider offering chiropractic services, physical therapy, occupational therapy, speech therapy, acupuncture, massage, and/or complementary and alternative medicine (CAM) services to join a Tivity network. Excluded from the Settlement Class are: (1) the trial judge presiding over this case; (2) Tivity, as well as any parent, subsidiary, affiliate or control person of Tivity, and the officers, directors, agents, servants or employees of Tivity; (3) any of the Released Parties; (4) the immediate family of any such person(s); (5) any member of the Settlement Class who has timely opted out of the Settlement; and (6) Class Counsel and their employees.

6. Specifically, the Court finds, for settlement purposes and conditioned on final certification of the proposed class and on the entry of the Final Approval Order, that the Settlement Class satisfies the following factors of Federal Rule of Civil Procedure 23:

(a) Numerosity: There are hundreds of members of the proposed Settlement Class. The proposed Settlement Class is so numerous that joinder of all members is impracticable.

(b) Commonality: “[C]ommonality requires the plaintiff to demonstrate that the class members ‘have suffered the same injury,’” and the plaintiff’s common contention “must be of such a nature that it is capable of classwide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.” *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 131 S. Ct. 2541, 2551 (2011) (citation omitted). Here, the commonality requirement is satisfied. Multiple questions of law and fact centering on Defendant’s class-wide practices are common to the Plaintiff and the Settlement Class, are alleged to have injured all members of the Settlement Class in the same way, and would generate common answers central to the viability of the claims were this case to proceed to trial.

(c) Typicality: The Plaintiff’s claims are typical of the Settlement Class because they concern the same alleged marketing practices of Tivity, arise from the same legal theories, and allege the same types of harm and entitlement to relief. Rule 23(a)(3) is therefore satisfied. *See In re Drexel Burnham Lambert Grp.*, 960 F.2d 285, 291 (2d Cir. 1992) (typicality “is satisfied when each class member’s claim arises from the same course of events, and each class member makes similar legal arguments to prove the defendant’s liability”).

(d) Adequacy: Adequacy under Rule 23(a)(4) requires: (1) a plaintiff’s attorney to be qualified, experienced, and generally able to conduct the proposed litigation; and (2) a plaintiff must not have interests antagonistic to those of the class. *Id.* Here, Rule 23(a)(4) is satisfied because there are no conflicts of interest between the Plaintiff and the Settlement Class, and Plaintiff has retained competent counsel to represent him and the Settlement Class. Class Counsel regularly engage in consumer class litigation, complex litigation, and other litigation similar to this

Action, and have dedicated substantial resources to the prosecution of the Action. Moreover, the Plaintiff and Class Counsel have vigorously and competently represented the Settlement Class in the Action.

(e) Predominance and Superiority: Rule 23(b)(3) is satisfied because the common legal and alleged factual issues here predominate over individualized issues, and resolution of the common issues for the members of the Settlement Class in a single, coordinated proceeding is superior to thousands of individual lawsuits addressing the same legal and factual issues. Rule 23(b)(3)'s predominance requirements test "whether proposed classes are sufficiently cohesive to warrant adjudication by representation. The requirement's purpose is to ensure that the class will be certified only when it would achieve economies of time, effort, and expense, and promote uniformity of decision as to persons similarly situated, without sacrificing procedural fairness or bringing about other undesirable results." *In re Am. Int'l Grp. Sec. Litig.*, 689 F.3d 229, 239-40 (2d Cir. 2012) (internal citation omitted). Here, common questions present a significant aspect of the case and can be resolved for all members of the Settlement Class in a single adjudication. In a liability determination, those common issues would predominate over any issues that are unique to individual members of the Settlement Class. Moreover, each member of the Settlement Class has claims that arise from the same or similar alleged marketing practices of Tivity as well as the same legal theories.

7. The Court appoints Plaintiff, Lackawanna Chiropractic, P.C., as Class Representative.

8. The Court appoints the following people and firms as Class Counsel: Avi R. Kaufman of Kaufman P.A. and Stefan Coleman of Law Offices of Stefan Coleman, P.A.

9. The Court recognizes that Defendant reserves its defenses and objections against and right to oppose any request for class certification in the event that the proposed Settlement does

not become final for any reason. Defendant also reserves its defenses to the merits of the claims asserted in the event the Settlement does not become final for any reason.

#### Preliminary Approval of the Settlement

10. At the preliminary approval stage, the Court's task is to evaluate whether the Settlement is within the "range of possible approval." *Davis v. J.P. Morgan Chase & Co.*, 775 F. Supp. 2d 601, 607 (W.D.N.Y. 2011); 4 *Newberg on Class Actions* § 11.26. Settlement negotiations that involve arm's length, informed bargaining with the aid of experienced counsel support a preliminary finding of fairness. *See Manual for Complex Litigation*, Third, § 30.42 (West 1995) ("A presumption of fairness, adequacy, and reasonableness may attach to a class settlement reached in arm's-length negotiations between experienced, capable counsel after meaningful discovery.") (internal quotation marks omitted).

11. The Court preliminarily approves the Settlement, together with all exhibits thereto, as fair, reasonable, and adequate. The Court finds that the Settlement was reached in the absence of collusion, is the product of informed, good-faith, arm's-length negotiations between the Parties and their capable and experienced counsel. The Court further finds that the Settlement, including the exhibits thereto, is within the range of reasonableness and possible judicial approval, such that: (a) a presumption of fairness is appropriate for the purposes of preliminary settlement approval; and (b) it is appropriate to effectuate notice to the Settlement Class, as set forth below and in the Settlement, and schedule a Final Approval Hearing to assist the Court in determining whether to grant Final Approval to the Settlement and enter a Final Approval Order.

#### Approval of Class Notice and the Notice Program

12. The Court approves the form and content of the Notice and Claim Form, substantially in the forms attached as Exhibits 1 through 3 to the Settlement. The Court further finds that the

Notice Program described in the Settlement is the best practicable under the circumstances. The Notice Program is reasonably calculated under the circumstances to inform the Settlement Class of the pendency of the Action, certification of a Settlement Class, the terms of the Settlement, Class Counsel's Fee Application and the request for Service Award for Plaintiff, the claim process, and their rights to opt-out of the Settlement Class or object to the Settlement. The Notices and Notice Program constitute sufficient notice to all persons entitled to notice. The Notices and Notice Program satisfy all applicable requirements of law, including, but not limited to, Federal Rule of Civil Procedure 23 and the Constitutional requirement of due process.

13. Angeion Group shall serve as the Settlement Administrator.

14. The Administrator shall implement the Notice Program, as set forth below and in the Settlement, and the Claims Process using the Notices and Claim Form substantially in the forms attached as Exhibits to the Settlement and approved by this Preliminary Approval Order. Notice shall be provided to the members of the Settlement Class pursuant to the Notice Program, as specified in the Settlement and approved by this Preliminary Approval Order. The Notice Program shall include Mail Notice and Long-Form Notice, as set forth in the Settlement and below.

15. The Administrator shall administer Mail Notice as set forth in the Settlement. Mail Notice shall be completed no later than 45 days prior to the Final Approval Hearing.

16. The Administrator shall establish a Settlement Website as a means for Settlement Class members to obtain notice of, and information about, the Settlement. The Settlement Website shall be established as soon as practicable following Preliminary Approval, but no later than before commencement of the Notice Program. The Settlement Website shall include hyperlinks to the Settlement, the Long-Form Notice, the Preliminary Approval Order, and other such documents as



Class Counsel and counsel for Defendant agree to include. These documents shall remain on the Settlement Website at least until the Final Approval Hearing.

17. The Administrator is directed to perform all substantive responsibilities with respect to effectuating the Notice Program and claims process, as set forth in the Settlement.

Final Approval Hearing, Opt-Outs, and Objections

18. A Final Approval Hearing shall be held before this Court on \_\_\_\_\_, 2020 at \_\_\_\_\_.m. to determine whether to grant Final Approval to the Settlement and to enter a Final Approval Order, and whether Class Counsel's Fee Application and request for a Service Award for the Class Representative should be granted.

19. Any person within the Settlement Class who wishes to be excluded from the Settlement may exercise their right to opt-out of the Settlement by following the opt-out procedures set forth in the Settlement and in the Notice at any time prior to the Opt-Out Deadline. To be valid and timely, opt-out requests must be received by those listed in the Long-Form Notice on or before the Opt-Out Deadline, which is 30 days before the Final Approval Hearing, and mailed to the addresses indicated in the Long Form Notice.

20. Any Settlement Class member may object to the Settlement, Class Counsel's Fee Application, or the request for a Service Award for Plaintiff. Tivity also may object to Class Counsel's Fee Application and/or the request for a Service Award. Any such objections must be mailed to the Clerk of the Court, Class Counsel, and Defendant's Counsel, at the addresses indicated in the Long-Form Notice. For an objection to be considered by the Court, the objection must be postmarked no later than 30 days before the Final Approval Hearing, as set forth in the Notice. To be valid, an objection must include the following information:

- a) the name of the Action;

- b) the objector's full name (or, if a business, business name), address, telephone number, and fax number at which the Tivity Fax(es) was (were) received;
- c) an explanation of the basis upon which the objector claims to be a Settlement Class Member;
- d) all grounds for the objection, accompanied by any legal support for the objection known to the objector or his counsel; and
- e) the objector's signature (an attorney's signature is not sufficient).

Further Papers in Support of Settlement and Attorney's Fee Application

21. Plaintiff and Class Counsel shall file their Motion for Final Approval of the Settlement, Fee Application and request for a Service Award for Plaintiff, no later than \_\_\_\_\_, which is 45 days before the Final Approval Hearing.

22. Plaintiff and Class Counsel shall file their responses to timely filed objections to the Motion for Final Approval of the Settlement, the Fee Application and/or request a Service Award for Plaintiff no later than \_\_\_\_\_, which is 15 days before the Final Approval Hearing.

Effect of Failure to Approve Settlement

23. If the Settlement is not finally approved by the Court, or for any reason the Parties fail to obtain a Final Approval Order as contemplated in the Settlement, or the Settlement is terminated pursuant to its terms for any reason, then the following shall apply:

(a) All orders and findings entered in connection with the Settlement shall become null and void and have no further force and effect, shall not be used or referred to for any purpose whatsoever, and shall not be admissible or discoverable in any other proceeding;

(b) Nothing in this Preliminary Approval Order is, or may be construed as, any admission or concession by or against Tivity or Plaintiff on any point of fact or law; and

(c) Neither the Settlement terms nor any publicly disseminated information regarding the Settlement, including, without limitation, the Class Notice, court filings, orders and public statements, may be used as evidence. In addition, neither the fact of, nor any documents relating to, either Party's withdrawal from the Settlement, any failure of the Court to approve the Settlement and/or any objections or interventions may be used as evidence.

Stay/Bar of Other Proceedings

24. The Action is re-opened and all proceedings in the Action are stayed until further order of the Court, except as may be necessary to implement the terms of the Settlement. Pending final determination of whether the Settlement should be approved, Plaintiff, all persons in the Settlement Class, and persons purporting to act on their behalf are enjoined from commencing or prosecuting (either directly, representatively or in any other capacity) against any of the Released Parties any action or proceeding in any court, arbitration forum or tribunal asserting any of the Released Claims.

25. Based on the foregoing, the Court sets the following schedule for the Final Approval Hearing and the actions which must take place before and after it:

<u>Event</u>	<u>Date</u>
Deadline for Completion of Mailed Notice Program	45 days prior to the Final Approval Hearing
Deadline for filing papers in support of Final Approval of the Settlement and Class Counsel's application for an award of attorneys' fees and expenses	No later than 45 days prior to the Final Approval Hearing
Opt-Out and Objection Deadline	30 days prior to the Final Approval Hearing

Responses to Objections	15 days prior to the Final Approval Hearing
The Final Approval Hearing	At least 90 days after Preliminary Approval
Claims Deadline	14 days after the Final Approval Hearing

**DONE AND ORDERED** in Buffalo, New York this \_\_\_ day of March, 2020.

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Lawrence J. Vilardo  
United States District Court Judge

# EXHIBIT 5

IN THE UNITED STATES DISTRICT COURT  
THE WESTERN DISTRICT OF NEW YORK

**LACKAWANNA CHIROPRACTIC P.C.**, a  
New York professional corporation,  
individually and on behalf of all others  
similarly situated,

*Plaintiff,*

v.

**TIVITY HEALTH SUPPORT, LLC**, a  
Delaware limited liability company,

*Defendant.*

Case No. 1:18-cv-00649-LJV

**CLASS ACTION**

**[PROPOSED] ORDER GRANTING FINAL APPROVAL TO  
CLASS ACTION SETTLEMENT AND FINAL JUDGMENT**

On \_\_\_\_\_, 2020, the Court granted preliminary approval to the proposed class action settlement set forth in the Settlement Agreement (the “Settlement Agreement”) dated as of March \_\_, 2020 between Plaintiff Lackawanna Chiropractic P.C., on behalf of itself and a class of similarly situated persons, and Defendant Tivity Health Support, LLC (referred to as “Tivity” or “Defendant”) (collectively, the “Parties”). The Court also provisionally certified the Settlement Class<sup>1</sup> for settlement purposes, approved the procedure for giving Notice to the members of the Settlement Class, and set a Final Approval Hearing to take place on \_\_\_\_\_.

On \_\_\_\_\_, the Court held a duly noticed Final Approval Hearing to consider: (1) whether the terms and conditions of the Settlement Agreement are fair, reasonable, and adequate; (2) whether a judgment should be entered dismissing this Action on the merits and with prejudice in favor of Defendant and other Released Parties and against Plaintiff and other

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<sup>1</sup> Unless otherwise defined, capitalized terms herein have the definitions found in the Settlement Agreement.

Releasing Parties; and (3) whether and in what amount to award counsel for the Settlement Class as attorneys' fees and expenses and whether and in what amount to award a Service Award to Plaintiff.

**NOW, THEREFORE, IT IS HEREBY ORDERED THAT:**

**I. JURISDICTION OF THE COURT**

1. The Court has personal jurisdiction over the parties and members of the Settlement Class, venue is proper, and the Court has subject matter jurisdiction to approve the Agreement, including all Exhibits thereto, and to enter this Final Approval Order. Without in any way affecting the finality of this Final Approval Order, this Court hereby retains jurisdiction as to all matters relating to administration, consummation, enforcement, and interpretation of the Settlement Agreement and of this Final Approval Order, and for any other necessary purpose.

2. The Settlement Agreement was negotiated at arm's length by experienced counsel who were fully informed of the facts and circumstances pertaining to this Action and of the strengths and weaknesses of their respective positions. The Settlement Agreement was reached after the Parties had engaged a mediator and engaged in extensive settlement discussions and after the exchange of information, including information about the size and scope of the Settlement Class. Counsel for the Parties were therefore well positioned to evaluate the benefits of the Settlement Agreement, taking into account the expense, risk, and uncertainty of protracted litigation.

3. The Court finds that the prerequisites for a class action under Fed. R. Civ. P. 23 have been satisfied for settlement purposes for each Settlement Class Member in that: (a) the number of members of the Settlement Class is so numerous that joinder of all members thereof is impracticable; (b) there are questions of law and fact common to the Settlement Class; (c) the

claims of Plaintiff are typical of the claims of the Settlement Class he seeks to represent; (d) Plaintiff have and will continue to fairly and adequately represent the interests of the Settlement Class for purposes of entering into the Settlement Agreement; (e) the questions of law and fact common to the Settlement Class predominate over any questions affecting any individual member of the Settlement Class; (f) the Settlement Class is ascertainable; and (g) a class action is superior to the other available methods for the fair and efficient adjudication of the controversy.

## **II. CERTIFICATION OF SETTLEMENT CLASS**

4. Pursuant to Fed. R. Civ. P. 23, this Court hereby finally certifies the Settlement Class, as identified in the Settlement Agreement: All individuals and entities within the United States who were sent a Tivity Fax by or on behalf of Tivity recruiting a provider offering chiropractic services, physical therapy, occupational therapy, speech therapy, acupuncture, massage, and/or complementary and alternative medicine (CAM) services to join a Tivity network. Excluded from the Settlement Class are: (1) the trial judge presiding over this case; (2) Tivity, as well as any parent, subsidiary, affiliate or control person of Tivity, and the officers, directors, agents, servants or employees of Tivity; (3) any of the Released Parties; (4) the immediate family of any such person(s); (5) any member of the Settlement Class who has timely opted out of the Settlement; and (6) Class Counsel and their employees.

## **III. APPOINTMENT OF CLASS REPRESENTATIVES AND CLASS COUNSEL**

5. The Court finally appoints Avi R. Kaufman of Kaufman P.A. and Stefan Coleman of Law Offices of Stefan Coleman, P.A. as Class Counsel for the Settlement Class.

6. The Court finally designates Plaintiff as the Class Representative.

## **IV. NOTICE AND CLAIMS PROCESS**

7. The Court makes the following findings on notice to the Settlement Class:



(a) The Court finds that the distribution of the Notice, as provided for in the Settlement Agreement, (i) constituted the best practicable notice under the circumstances to Settlement Class members, (ii) constituted notice that was reasonably calculated, under the circumstances, to apprise members of the Settlement Class of, among other things, the pendency of the Action, the nature and terms of the proposed Settlement, their right to object or to exclude themselves from the proposed Settlement, and their right to appear at the Final Approval Hearing, (iii) was reasonable and constituted due, adequate, and sufficient notice to all persons entitled to be provided with notice, and (iv) complied fully with the requirements of Fed. R. Civ. P. 23, the United States Constitution, the Rules of this Court, and any other applicable law.

(b) The Court finds that the Notice and methodology set forth in the Settlement Agreement, the Preliminary Approval Order, and this Final Approval Order (i) constitute the most effective and practicable notice of the Final Approval Order, the relief available to members of the Settlement Class pursuant to the Final Approval Order, and applicable time periods; (ii) constitute due, adequate, and sufficient notice for all other purposes to all members of the Settlement Class; and (iii) comply fully with the requirements of Fed. R. Civ. P. 23, the United States Constitution, the Rules of this Court, and any other applicable laws.

## **V. FINAL APPROVAL OF THE CLASS ACTION SETTLEMENT**

8. The Settlement Agreement is finally approved in all respects as fair, reasonable and adequate. The terms and provisions of the Settlement Agreement, including all Exhibits thereto, have been entered into in good faith and are hereby fully and finally approved as fair, reasonable, and adequate as to, and in the best interests of, each of the Parties and the Settlement Class.

## **VI. ADMINISTRATION OF THE SETTLEMENT**

9. The Parties are hereby directed to implement the Settlement Agreement according to its terms and provisions. The Settlement Administrator is directed to provide Approved Claim Payments to those Settlement Class Members who submit Approved Claims.

10. [The Court hereby approves Class Counsel's request for attorneys' fees and expenses, and awards Class Counsel \$ \_\_\_\_\_ as reasonable attorneys' fees and expenses, inclusive of the award of reasonable costs incurred in this Action. The Court finds that the requested fees are reasonable under the percentage of the fund for the reasons set forth herein. The award of attorneys' fees and expenses to Class Counsel shall be paid by Tivity within the time period and manner set forth in the Settlement Agreement.

11. The Court hereby awards Class Counsel for their time incurred and expenses advanced. The Court has concluded that: (a) Class Counsel achieved a favorable result for the Class by obtaining Defendant's agreement to make significant funds available to the Settlement Class, subject to submission of valid claims by eligible Settlement Class members; (b) Class Counsel devoted substantial effort to pre- and post-filing investigation, legal analysis, and litigation; (c) Class Counsel prosecuted the Settlement Class's claims on a contingent fee basis, investing significant time and accumulating costs with no guarantee that they would receive compensation for their services or recover their expenses; (d) Class Counsel employed their knowledge of and experience with class action litigation in achieving a valuable settlement for the Settlement Class, in spite of Defendant's possible legal defenses and its experienced and capable counsel; (3) Class Counsel have standard contingent fee agreements with Plaintiff, who has reviewed the Settlement Agreement and been informed of Class Counsel's fee request and has approved it; and (f) the Notice informed the members of the Settlement Class of the amount and

nature of Class Counsel's fee and cost request under the Settlement Agreement, Class Counsel filed and posted their Petition in time for Settlement Class members to make a meaningful decision whether to object to the Class Counsel's fee request, and \_\_\_\_ members of the Settlement Class objected.

12. The Court has confirmed the reasonableness of fees and costs requested. Attorneys whose work created a common fund for the benefit of a group of plaintiffs may receive "reasonable" attorneys' fees from the fund. *Victor v. Argent Classic Convertible Arbitrage Fund L.P.*, 623 F.3d 82, 86 (2d Cir. 2010). Courts "may award attorneys' fees in common fund cases under either the 'lodestar' method or the 'percentage of the fund' method," although "the trend in this Circuit is toward the percentage method." *McDaniel v. Cty. Of Schenectady*, 595 F.3d 411, 417 (2d Cir. 2010). "The trend in this Circuit is toward the percentage method, which directly aligns the interests of the class and its counsel and provides a powerful incentive for the efficient prosecution and early resolution of litigation." *Wal-Mart Stores, Inc. v. Visa U.S.A. Inc.*, 396 F.3d 96, 122 (2d Cir. 2005) (internal citation omitted). In approving applications for attorneys' fees based upon either the percentage-of-the-fund or the lodestar approach, courts in this Circuit consider the following factors: (1) time and labor expended by counsel; (2) magnitude and complexity of the litigation; (3) risk of the litigation; (4) quality of the representation; (5) requested fee in relation to the settlement; and (6) public policy considerations. *Goldberger v. Integrated Res., Inc.*, 209 F.3d 43, 50 (2d Cir. 2000); *Wal-Mart Stores, Inc.*, 396 F.3d at 122.

13. Here, using either the percentage method or the lodestar method, and applying the *Goldberger* factors, the requested fee and expense award is reasonable. The Court finds and concludes that the following applicable factors support the requested award of attorneys' fees and costs:

a. *Time and Labor Expended by Counsel*

The work required of Class Counsel was extensive. These efforts required work representing Plaintiff and the Settlement Class without compensation. The substantial work necessitated by this case diverted Class Counsel from putting time and resources into other matters.

b. *Magnitude and Complexities of the Litigation*

This case involved complex substantive issues which presented a significant risk of nonpayment, including uncertainty in class certification, contested issues regarding interpretation of the Telephone Consumer Protection Act (“TCPA”) in a setting of developing case law and FCC rulings and recovery being dependent on a successful outcome, which was uncertain.

c. *Risk of Litigation*

This case involved complex substantive issues which presented a significant risk of nonpayment, and Class Counsel achieved excellent monetary results for the Settlement Class.

d. *Quality of Representation*

Class Counsel achieved a settlement that confers substantial monetary benefits to the Settlement Class despite the complex litigation against a sophisticated defendant represented by top-tier counsel. The Settlement will produce a cash benefit that is well within the range of recoveries established by other court approved TCPA class action settlements. This outcome was made possible by Class Counsel’s extensive experience in litigating class actions of similar size, scope, and complexity to the instant action. Class Counsel regularly engage in complex litigation involving consumer issues, all have been class counsel in numerous consumer class action cases.

e. *Requested Fee in Relation to the Settlement*

Many similar TCPA class settlements provide for one third of the fund obtained for the class. *See Melito v. Am. Eagle Outfitters, Inc.*, No. 14-CV-2440 (VEC), 2017 U.S. Dist. LEXIS

146343, at \*46 (S.D.N.Y. Sep. 8, 2017) (awarding attorney fees equal to thirty (30) percent of the settlement fund). Common-fund attorney fee awards of one-third are consistent with the trend in this Circuit. *See, e.g., Globus v. Pioneer Credit Recovery, Inc.*, No. 15-CV-152V, 2016 U.S. Dist. LEXIS 102817, at \*7 (W.D.N.Y. July 27, 2016) (awarding attorney fee equaling approximately 30 percent of the settlement fund); *Velez v. Novartis Pharms. Corp.*, No. 04 Civ. 09194 (CM), 2010 WL 4877852, at \*21 (S.D.N.Y. Nov. 30, 2010) (collecting cases supporting the proposition that “[d]istrict courts in the Second Circuit routinely award attorneys” fees that are 30 percent or greater of the common fund). Here, Class Counsel is awarded approximately \_\_\_\_\_% of the value of the Settlement obtained for the Class.

f. *Public Policy Considerations*

Rewarding attorneys in class actions is important because, absent class actions, most individual claimants would lack the resources to litigate, as individual recoveries are often too small to justify the burden and expense of litigation. *In re Telectronics Pacing Sys., Inc.*, 137 F. Supp. 2d 1029, 1043 (S.D. Ohio 2001) (“Attorneys who take on class action matters serve a benefit to society and the judicial process by enabling ... claimants to pool their claims and resources” to “achieve a result they could not obtain alone”); *see also Goldberger*, 209 F.3d at 51 (“There is also commendable sentiment in favor of providing lawyers with sufficient incentive to bring common fund cases that serve the public interest”). By way of this litigation and the resulting settlement, Class Counsel served the function of protecting the rights of hundreds of consumers who may not have otherwise been aware of their rights or had the ability to pursue individual actions.

14. The Court awards a Service Award in the amount of \$ \_\_\_\_\_ to Plaintiff payable pursuant to the terms of the Settlement Agreement.]<sup>2</sup>

## **VII. RELEASE OF CLAIMS**

15. Upon entry of this Final Approval Order, all Releasing Parties shall, by operation of this Final Approval Order, have fully, finally and forever released, relinquished and discharged Defendant and the other Released Parties from the Released Claims as set forth in the Settlement Agreement

16. Furthermore, all members of the Settlement Class who did not validly and timely submit requests for exclusion in the manner provided in the Agreement are hereby permanently barred and enjoined from filing, commencing, prosecuting, maintaining, intervening in, participating in, conducting or continuing, either directly or in any other capacity, either individually or as a class, any action or proceeding in any court, agency, arbitration, tribunal or jurisdiction, asserting any of the Released Claims, or seeking an award of fees and costs of any kind or nature whatsoever and pursuant to any authority or theory whatsoever, relating to or arising from the Action or that could have been brought in the Action and/or as a result of or in addition to those provided by the Settlement Agreement.

17. The terms of the Settlement Agreement and of this Final Approval Order, including all Exhibits thereto, shall be forever binding on, and shall have *res judicata* and preclusive effect in, all pending and future lawsuits maintained by Plaintiff and all other Releasing Parties, as well as their heirs, executors and administrators, successors, and assigns.

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<sup>2</sup> Under the terms of the Settlement, Tivity fully reserves its rights to object to Class Counsel's request for an award of attorneys' fees and expenses, and the request for a Service Award, and accordingly Tivity reserves its rights to object to the language of Paragraphs 10 through 14 of this proposed Final Approval Order.

18. The Releases, which are set forth in Section XIII of the Settlement Agreement and which are also set forth below, are expressly incorporated herein in all respects and are effective as of the date of this Final Approval Order; and the Released Parties are forever released, relinquished, and discharged from all Released Claims.

(a) The Settlement Agreement and Releases do not affect the rights of members of the Settlement Class who timely and properly submit a request for exclusion from the Settlement in accordance with the requirements of the Settlement Agreement.

(b) The administration and consummation of the Settlement as embodied in the Settlement Agreement shall be under the authority of the Court. The Court shall retain jurisdiction to protect, preserve, and implement the Settlement Agreement, including, but not limited to, enforcement of the Releases. The Court expressly retains jurisdiction in order to enter such further orders as may be necessary or appropriate in administering and implementing the terms and provisions of the Settlement Agreement.

(c) The Settlement Agreement shall be the exclusive remedy for any and all Settlement Class Members and the Released Parties shall not be subject to liability or expense for any of the Released Claims to any Settlement Class Member(s).

(d) The Releases shall not preclude any action to enforce the terms of the Settlement Agreement, including participation in any of the processes detailed therein. The Releases set forth herein and in the Settlement Agreement are not intended to include the release of any rights or duties of the Parties arising out of the Settlement Agreement, including the express warranties and covenants contained therein.

19. On the Effective Date, the Releasing Parties, and each of them, will be forever barred and permanently enjoined from directly, indirectly, representatively or in any other

capacity, filing, commencing, prosecuting, continuing, litigating, intervening in, participating in as class members or otherwise, or receiving any benefits or other relief from any lawsuit, any arbitration, or any administrative, regulatory, or other proceeding against any of the Released Parties in any jurisdiction based on or relating in any way to the Released Claims, and the Releasing Parties, and each of them, shall be forever barred and permanently enjoined from filing, commencing, or prosecuting any lawsuit individually or as a class action against any of the Released Parties (including by seeking to amend a pending complaint to include class allegations or by seeking class certification in a pending action in any jurisdiction) based on or relating in any way to the Released Claims on behalf of members of the Settlement Class who have not timely excluded themselves from the Settlement Class.

#### **VIII. NO ADMISSION OF LIABILITY**

20. Neither the Settlement Agreement, nor any of its terms and provisions, nor any of the negotiations or proceedings connected with it, nor any of the documents or statements referred to therein, nor this Final Approval Order, nor any of its terms and provisions, shall be:

(a) offered by any person or received against Defendant or any Released Party as evidence of, or construed as or deemed to be evidence of, any presumption, concession, or admission by Defendant of the truth of the facts alleged by any person, the validity of any claim that has been or could have been asserted in the Action or in any other litigation or judicial or administrative proceeding, the deficiency of any defense that has been or could have been asserted in the Action or in any litigation, or of any liability, negligence, fault, or wrongdoing by Defendant or any Released Party;



(b) offered by any person or received against Defendant or any Released Party as evidence of a presumption, concession, or admission of any fault or violation of any law by Defendant or any Released Party; or

(c) offered by any person or received against Defendant or any Released Party as evidence of a presumption, concession, or admission with respect to any liability, negligence, fault, or wrongdoing in any civil, criminal, or administrative action or proceeding.

## **IX. OTHER PROVISIONS**

21. This Final Approval Order and the Settlement Agreement (including the Exhibits thereto) may be filed in any action against or by any Released Party (as that term is defined in the Settlement Agreement) to support a defense of *res judicata*, collateral estoppel, release, good faith settlement, judgment bar or reduction, or any theory of claim preclusion or issue preclusion or similar defense or counterclaim.

22. Without further order of the Court, the Parties may agree to reasonably necessary extensions of time to carry out any of the provisions of the Settlement Agreement.

23. In the event that the Effective Date does not occur, this Final Approval Order shall automatically be rendered null and void and shall be vacated and, in such event, all orders entered and releases delivered in connection herewith shall be null and void. In the event that the Effective Date does not occur, the Settlement Agreement shall become null and void and be of no further force and effect, neither the Settlement Agreement nor the Court's Orders, including this Order, shall be used or referred to for any purpose whatsoever, and the Parties shall retain, without prejudice, any and all objections, arguments, and defenses with respect to class certification, including the right to argue that no class should be certified for any purpose, and with respect to any claims or allegations in this Action.

24. This Action, including all individual claims and class claims presented herein, is hereby dismissed on the merits and with prejudice against Plaintiff and all other Settlement Class members, without fees or costs to any party except as otherwise provided herein.

**DONE AND ORDERED** in Buffalo, New York this \_\_ day of \_\_\_\_\_, 2020.

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Lawrence J. Vilardo  
United States District Court Judge

# EXHIBIT 6

# FAX

**To:** [REDACTED]  
Company:  
Fax: 850878 [REDACTED]  
Phone:

**From:**  
Fax:  
Phone:  
E-mail: Kagan.Anderson@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Wednesday, February 7, 2018 4:44:16 PM  
**Number of pages including this cover sheet:** 02

Hi,

My name is Kagan Anderson with Tivity Health on behalf of WholeHealth Networks and I'm reaching out to you since you were recommended by a member of WHN as a preferred Provider!! With that being said, I would like to invite you to become a **WholeHealth Provider for 2018!** We have a program for the 50+ age group specifying in **Health and Fitness** which is a voucher program; as we want to introduce our members to Alternative Medicine. You are also eligible to join the Humana and Aetna 2018 Network. Also, this no cost program is a great opportunity as it will expand your clientele by your facility being added to our referral lists! If you would like more information I will be more than happy to email our group summary and fee schedules to you.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years.

This is a great opportunity to help the 50 plus age group in your area as well as enhancing the expansion of your business. If this is something that interests you, please follow the steps below. I have also attached the Contract, W-9 and Group Summary for your review

Thank you so much for your time today! If you have any questions please contact **WHN Customer Service at 800-274-7526 or my personal line at 480-692-2706**

The attached Group Summary details the plan benefits.

1. Complete, sign and return first page of the Participating Practitioner Agreement and your W-9 for payment information.
2. Completed documents may be returned to me by at [Kagan.Anderson@tivityhealth.com](mailto:Kagan.Anderson@tivityhealth.com) or FAX 888-492-1026 (if you decide to fax them please let me know so I can check the faxes.)

Upon completion of the WHN Application process, you will receive a WHN Welcome Letter and additional access to WholeHealthPro.com for more educational and contract information.

If you have any questions regarding the enclosed information, please feel free to contact me by email or at the number below. We look forward to having you join us in offering this benefit to eligible patients in the area.

Sincerely,

**Kagan Anderson • Recruiter Specialist**

**Tivity Health • [tivityhealth.com](http://tivityhealth.com)**

**o • 480.692.2706 a • 1445 S. Spectrum Blvd., Chandler, AZ 85286**

**[Kagan.Anderson@tivityhealth.com](mailto:Kagan.Anderson@tivityhealth.com)**



The Vision  
• Customer focused • Fast • Efficient  
• Affordable • A member driven health system

# FAX

**To:** [REDACTED]

Company:

Fax: 937439 [REDACTED]

Phone:

**From:**

Fax:

Phone:

E-mail: Naquanna.Ellis@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Tuesday, April 10, 2018 6:40:38 PM  
**Number of pages including this cover sheet:** 02



1445 S. Spectrum Blvd., Chandler, AZ 85286

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a complementary health component, providing members with a \$20 voucher to be applied for services. The first voucher is not redeemable, and every voucher thereafter is redeemable. **We hope you consider joining today!**

If you are interested in joining, I can forward you the appropriate contracts via email or you can complete the application online at <https://www.wholehealthpro.com/>

Sincerely,

**Nikki Ellis • Recruiter**

**Tivity Health • [tivityhealth.com](http://tivityhealth.com)**

**o • 480.692.2713 a • 1445 S. Spectrum Blvd., Chandler, AZ 85286**

**[Nikki.Ellis@tivityhealth.com](mailto:Nikki.Ellis@tivityhealth.com)**

# FAX

**To:** [REDACTED]  
Company:  
Fax: 949916 [REDACTED]  
Phone:

**From:**  
Fax:  
Phone:  
E-mail: Melissa.Gorsuch@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Tuesday, February 20, 2018 2:43:50 PM  
**Number of pages including this cover sheet:** 02



Greetings,

My name is Melissa Gorsuch, a recruiter with Tivity Health, WholeHealth Networks.

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for **Acupuncturist, Chiropractors and Massage Therapist** for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a Complementary Alternative Medicine component providing members with a \$20 voucher to be applied for services.

I'd appreciate the opportunity to discuss this program further to determine if you are eligible and/or interested. I will follow up with you in 2-3 business days via phone.

If you have any questions prior to that, my contact information is below.

We look forward to having you join our network.

Visit our provider website [www.wholehealthpro.com/](http://www.wholehealthpro.com/)

**Melissa Gorsuch** • Recruiter – WHL Provider Network Recruiting  
**Tivity Health** • [tivityhealth.com](http://tivityhealth.com)

• 480.692.2724 a • 1445 S. Spectrum Blvd., Chandler, AZ 85286

[Melissa.Gorsuch@tivityhealth.com](mailto:Melissa.Gorsuch@tivityhealth.com)



Our Values

• Customer-focused • Trust • Excellence  
• Proactive • Empowerment with Results

# FAX

**To: Provider**

Company:

Fax: 415386 [REDACTED]

Phone:

**From:**

Fax:

Phone:

E-mail: [Melissa.Gorsuch@tivityhealth.com](mailto:Melissa.Gorsuch@tivityhealth.com)

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**NOTES:**

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**Date and time of transmission:** Tuesday, April 24, 2018 4:12:50 PM  
**Number of pages including this cover sheet:** 02

**Dear Practitioner,**

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for our Health and Fitness product and for Humana Covered Acupuncture for Medicare Advantage members.

<https://www.wholehealthpro.com/>



### Announcements

- Grow your business! Click here to get started: [WholeHealth Living Network Application](#)
- View an introductory overview of the new features: [Educational Reference](#)
- Navigate back to the old WholeHealthPro site: [Legacy WholeHealthPro Portal](#)

A secure online resource portal  
for our participating practitioners.

A convenient way for our practitioners to conduct daily office operations.



Access to the WHN authorization web portal



View the WHN Provider Manual

I would like to schedule time to follow up with you to determine which contractual document is needed to join our network.

What is a good day and time to follow up?

**Thank you,**

**Melissa Gorsuch • Recruiter – WHL Provider Network Recruiting**

**Tivity Health • [tivityhealth.com](http://tivityhealth.com)**

**• 480.692.2724 • 1445 S. Spectrum Blvd., Chandler, AZ 85286**

**[Melissa.Gorsuch@tivityhealth.com](mailto:Melissa.Gorsuch@tivityhealth.com)**



**Our Values**

- Customer-Focused • Trust • Excellence
- Provocative • Empowerment with Results

# FAX

**To:** [REDACTED]  
Company:  
Fax: 210923 [REDACTED]  
Phone:

**From:**  
Fax:  
Phone:  
E-mail: Karl.Jones@tivityhealth.com

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## NOTES:

Dear [REDACTED]

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a complementary health component, providing members with a \$20 voucher to be applied for services.

Attached is the Contract and Amendment, and W-9. Please complete, sign and return to me by email or FAX to 480-393-1769 (if you decide to fax them please indicate my name on the cover page).

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**Date and time of transmission:** Monday, March 12, 2018 2:11:46 PM  
**Number of pages including this cover sheet:** 14

Form **W-9**  
(Rev. October 2007)  
Department of the Treasury  
Internal Revenue Service

## Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign  
Here**

Signature of  
U.S. person ▶

Date ▶

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.



Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>3</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.





20098 Ashbrook Place  
Suite 250, Ashburn, VA 20147  
Phone: 1-800-274-7526  
Fax: 1-888-492-1026  
Provider.Updates@TivityHealth.com

**WHOLEHEALTH LIVING® CHOICES NETWORK**  
**PARTICIPATING PRACTITIONER AGREEMENT**  
**CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS**

**INSTRUCTIONS**

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application, please return this application along with the necessary documentation to the address listed at the top of the page.

- ☐ Copy of license(s) if applicable
- ☐ Copy of insurance face sheet for professional and business liability policy
- ☐ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ☐ Signed release and attestation statement, with professional liability form if applicable.

**SIGNATURE LINE**

This Agreement is a contract between WholeHealth Networks, Inc. ("WHN"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("Practitioner"), (each a "Party," and together the "Parties") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("Terms").

**PRACTITIONER SPECIALTIES**

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acupuncture                     | <input type="checkbox"/> Hellerwork                             | <input type="checkbox"/> Nutritional Counselor                |
| <input type="checkbox"/> Acupuncture, MD/DO              | <input type="checkbox"/> Herbal Consultant                      | <input type="checkbox"/> Occupational Therapist               |
| <input type="checkbox"/> Acupuncture, DC/ND              | <input type="checkbox"/> Holistic Nurse Practitioner            | <input type="checkbox"/> Asian/Oriental Bodywork Therapist    |
| <input type="checkbox"/> Behavioral Health               | <input type="checkbox"/> Homeopathy                             | <input type="checkbox"/> Pain Practitioner                    |
| <input type="checkbox"/> Biofeedback                     | <input type="checkbox"/> Hypnotist, non-clinical                | <input type="checkbox"/> Personal Trainer/Exercise Specialist |
| <input type="checkbox"/> Childbirth Educators            | <input type="checkbox"/> Integrative Holistic Physician (MD/DO) | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Chinese Herbal Medicine         | <input type="checkbox"/> Massage Therapy                        | <input type="checkbox"/> Pilates Instructor                   |
| <input type="checkbox"/> Chiropractic Physician          | <input type="checkbox"/> Massage Therapy – Clinical             | <input type="checkbox"/> Post Birthing & Lactation Counselor  |
| <input type="checkbox"/> Dietician - Registered/Licensed | <input type="checkbox"/> Mind-Body Skills Instructor            | <input type="checkbox"/> Qi Gong Instructor                   |
| <input type="checkbox"/> Doulas                          | <input type="checkbox"/> Mindfulness-Based Stress Reduction     | <input type="checkbox"/> Reflexologist                        |
| <input type="checkbox"/> Energy Healing Practitioner     | <input type="checkbox"/> Teacher                                | <input type="checkbox"/> Tai Chi Instructor                   |
| <input type="checkbox"/> Feldenkrais                     | <input type="checkbox"/> Music Therapy                          | <input type="checkbox"/> Yoga Instructor                      |
| <input type="checkbox"/> Guided Imagery/Hypnotherapy     | <input type="checkbox"/> Naturopathic Physician                 |   |

**DISCOUNT AGREEMENT**

Practitioner will offer Services to Network participants at a discount of \_\_\_\_\_% (minimum of 10%-30%) to all of Practitioner's usual charges for Services (the "Discount"). If the Discount is left blank, Practitioner will provide a **20% Discount**. **Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.**

This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("Effective Date"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least **90 days (30 days for Practitioners in Illinois)** prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Accepted by: Martie Stabelfeldt, VP, WholeHealth Living

\_\_\_\_\_  
Date

<b>Primary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Office Contact:	_____
Website Address:	_____
Office Fax:	_____
Title:	_____
E-Mail:	_____
<b>Secondary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Office Contact:	_____
Website Address:	_____
Office Fax:	_____
Title:	_____
E-Mail Address:	_____

\* If you have additional locations, please list them on a separate sheet.

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_

Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_

Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_

Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_

Do you wish to have your Website listed on your profile? \_\_\_\_\_

What is your first year of practice? \_\_\_\_\_

What non-English languages do you or your office staff speak fluently? Please list \_\_\_\_\_

**Practice Focus:**

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**Payment Methods Accepted:**

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Visa       | <input type="checkbox"/> American Express | <input type="checkbox"/> Cash           |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover         | <input type="checkbox"/> Personal Check |

Average Fee Range: \$ \_\_\_\_\_ - \$ \_\_\_\_\_

Special Offers:

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**Correspondence/Communication Preference:**

- ☐ Email Email Address \_\_\_\_\_
- ☐ Fax Fax Number \_\_\_\_\_
- ☐ United States Postal Service

PRIMARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM
SECONDARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM

**DEFINITIONS**

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN- contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's healthcare license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

**TERMS AND CONDITIONS OF PARTICIPATION**

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-Discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii), not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants.

13. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
14. **Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
15. **Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
16. **Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
17. **Attorney's Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
18. **Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
19. **Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
20. **Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
21. **Waiver of Breach.** A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
22. **Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
23. **Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
24. **Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

#### **PARTICIPATION REQUIREMENTS**

**Liability/Insurance:** All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

**Practice Experience:** All practitioners are required to have 12 months experience in the credentialed practice specialty.

**Patient Services:** Practitioners must speak fluent English or have access to an interpreter.

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

**Premises Standards:** Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

**Practitioner Licensure Requirements:**

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

#### **NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

##### **QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.



**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have \_\_, have not \_\_ had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents.

I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Title or Designation (DC, LAc, GCFP, etc): \_\_\_\_\_

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**Current status of legal action:**

\_\_\_\_\_ Pending Court Date (if available): \_\_\_\_\_  
 \_\_\_\_\_ Dismissed or Dropped Date: \_\_\_\_\_  
 \_\_\_\_\_ Closed Date: \_\_\_\_\_

**Resolution:**

\_\_\_\_\_ No Payments  
 \_\_\_\_\_ Out of Court Settlement Amount: \$ \_\_\_\_\_  
 \_\_\_\_\_ Judgment or Award Amount: \$ \_\_\_\_\_

Date of Filing: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Professional Liability Insurer: \_\_\_\_\_

**Allegation:**

Details of incident including your role, relating events, and patient outcome:

Have you made any changes in your practice as a result of this incident? Attach separate sheet if required.

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

*Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.*

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists ( <b>MD/DO</b> ) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> <b>NDs and DCs</b> need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	<p>Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least <b>one</b> of the following programs:</p> <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley ® Method) <input type="checkbox"/> ASPO/Lamaze – Lamaze Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	<p>Documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least <b>one</b> of the following programs:</p> <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doulas of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> National Association of Postpartum Care Services <b>PLUS</b> <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage &amp; Bodywork <b>OR</b></li> <li><input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) <b>OR</b></li> <li><input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.)</li> </ul> <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters</b> of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Documentation of <b>supervised contact hours</b> performing clinical massage: <ul style="list-style-type: none"> <li><input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b></li> <li><input type="checkbox"/> 250 contact hours required for applicants with 1000 hour basic massage education that includes clinical assessment, clinical pathology, and clinical charting <b>OR</b></li> </ul> </li> </ul>

	<input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley, CA <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours or training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of <i>Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat</i> offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of <i>Practicum in MBSR</i> (formerly the <i>Internship Program</i> ) and/or <i>Teacher Development Intensive in MBSR</i> and/or <i>Supervision in MBSR</i> conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomate, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine (ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) <b>OR</b> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	<input type="checkbox"/> A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> <input type="checkbox"/> La Leche League International accredited Leader program <b>OR</b> International Board of Lactation Consultant Examiners (IBLCE)
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT) <b>OR</b> a registered with Yoga Alliance (200/500 hour certifications) <b>OR</b> a nationally certified course or training program <b>OR</b> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility



**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**WHOLEHEALTH NETWORKS, INC.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

WHN Choices Voucher Amendment 1.7.2018



**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY**

**Network Status:** Open

**Product Type:** The Health and Fitness Product

**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

**Program Design:**

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
  - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
  - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

**Questions:**

- Customer Service: 1-800-274-7526
- Address Changes: [provider.updates@tivityhealth.com](mailto:provider.updates@tivityhealth.com)
- Voucher redemption: Tivity Health WholeHealth Networks  
1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

WHN Choices Voucher Amendment 1.7.2018

# FAX

**To:** [REDACTED]

Company:

Fax: 254518 [REDACTED]

Phone:

**From:**

Fax:

Phone:

E-mail: Karl.Jones@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Wednesday, April 4, 2018 2:15:46 PM  
**Number of pages including this cover sheet:** 15



1445 S. Spectrum Blvd., Chandler, AZ 85286

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a complementary health component, providing members with a \$20 voucher to be applied for services. The first voucher is not redeemable, and every voucher thereafter is redeemable. We'd also like to offer you a \$500 dollar sign on bonus if you will complete, and submit docs to us by the end of this week. Offer valid until 5pm mst-4/6/18 . **We hope you consider joining today!**

If you are interested in joining, I have attached the appropriate contracts, you can also send them via fax at **480-383-6409**, or you can complete the application online at <https://www.wholehealthpro.com/>

WHOLE HEALTH PRO HOME FEATURES PROGRAMS CREDENTIALING CONTACT US REGISTER

**Announcements**

- Grow your business! Click here to get started: [WholeHealth Living Network Application](#)
- View an introductory overview of the new features: [Educational Reference](#)
- Navigate back to the old WholeHealthPro site: [Legacy WholeHealthPro Portal](#)

A secure online resource portal for our participating practitioners.  
A convenient way for our practitioners to conduct daily office operations.

- Access to the WHN authorization web portal
- View the WHN Provider Manual
- Claims address look-up
- View Participating Health Plan group summaries and fee schedules
- Obtain credentialing information
- Download clinical documents

Sincerely,

**Karl Jones • Provider Network Recruiter**

**Tivity Health • [tivityhealth.com](http://tivityhealth.com)**

**o • 480.692.2721 a • 1445 S. Spectrum Blvd., Chandler, AZ 85286**

**[Karl.Jones@tivityhealth.com](mailto:Karl.Jones@tivityhealth.com)**



1445 S. Spectrum Blvd., Chandler, AZ 85286



**Our Values**

- Customer-Focused • Trust • Excellence
- Provocative • Empowerment with Results

Form <b>W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer Identification Number and Certification</b>	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.



Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.





1445 S. Spectrum Blvd.  
Chandler, AZ 85286  
Phone: 1-800-274-7526  
Fax: 1-888-492-1026  
Provider.Updates@TivityHealth.com

**WHOLEHEALTH LIVING® CHOICES NETWORK**  
**PARTICIPATING PRACTITIONER AGREEMENT**  
**CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS**

**INSTRUCTIONS**

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application. Please return this application along with the necessary documentation to the address listed at the top of the page.

- ☐ Copy of license(s) if applicable
- ☐ Copy of insurance face sheet for professional and business liability policy
- ☐ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ☐ Signed release and attestation statement, with professional liability form if applicable

**SIGNATURE LINE**

This Agreement is a contract between WholeHealth Networks, Inc. ("WHN"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("Practitioner"), (each a "Party," and together the "Parties") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("Terms").

**PRACTITIONER SPECIALTIES**

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acupuncture                     | <input type="checkbox"/> Hellerwork                             | <input type="checkbox"/> Nutritional Counselor                |
| <input type="checkbox"/> Acupuncture, MD/DO              | <input type="checkbox"/> Herbal Consultant                      | <input type="checkbox"/> Occupational Therapist               |
| <input type="checkbox"/> Acupuncture, DC/ND              | <input type="checkbox"/> Holistic Nurse Practitioner            | <input type="checkbox"/> Asian/Oriental Bodywork Therapist    |
| <input type="checkbox"/> Behavioral Health               | <input type="checkbox"/> Homeopathy                             | <input type="checkbox"/> Pain Practitioner                    |
| <input type="checkbox"/> Biofeedback                     | <input type="checkbox"/> Hypnotist, non-clinical                | <input type="checkbox"/> Personal Trainer/Exercise Specialist |
| <input type="checkbox"/> Childbirth Educators            | <input type="checkbox"/> Integrative Holistic Physician (MD/DO) | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Chinese Herbal Medicine         | <input type="checkbox"/> Massage Therapy                        | <input type="checkbox"/> Pilates Instructor                   |
| <input type="checkbox"/> Chiropractic Physician          | <input type="checkbox"/> Massage Therapy – Clinical             | <input type="checkbox"/> Post Birthing & Lactation Counselor  |
| <input type="checkbox"/> Dietician - Registered/Licensed | <input type="checkbox"/> Mind-Body Skills Instructor            | <input type="checkbox"/> Qi Gong Instructor                   |
| <input type="checkbox"/> Doulas                          | <input type="checkbox"/> Mindfulness-Based Stress Reduction     | <input type="checkbox"/> Reflexologist                        |
| <input type="checkbox"/> Energy Healing Practitioner     | <input type="checkbox"/> Teacher                                | <input type="checkbox"/> Tai Chi Instructor                   |
| <input type="checkbox"/> Feldenkrais                     | <input type="checkbox"/> Music Therapy                          | <input type="checkbox"/> Yoga Instructor                      |
| <input type="checkbox"/> Guided Imagery/Hypnotherapy     | <input type="checkbox"/> Naturopathic Physician                 |   |

**DISCOUNT AGREEMENT**

Practitioner will offer Services to Network participants at a discount of \_\_\_\_\_% (minimum of 10%–30%) to all of Practitioner's usual charges for Services (the "Discount"). If the Discount is left blank, Practitioner will provide a **20% discount. Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.** This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("Effective Date"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least 90 days (30 days for Practitioners in Illinois) prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Practitioner's Signature  
Please print and sign.

\_\_\_\_\_  
Date

Choices Application Updated 08-2017 Page 1

**Primary Location:**

Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Title: \_\_\_\_\_  
 Website Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Secondary Location:**

Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, ZIP: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Title: \_\_\_\_\_  
 Website Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

\* If you have additional locations, please list them on a separate sheet.

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_  
 Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_  
 Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_  
 Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_  
 Do you wish to have your Website listed on your profile? \_\_\_\_\_  
 What is your first year of practice? \_\_\_\_\_  
 What non-English languages do you or your office staff speak fluently? Please list \_\_\_\_\_

**Practice Focus:**

\_\_\_\_\_  
 \_\_\_\_\_

**Payment Methods Accepted:**

- ☐ Visa ☐ American Express ☐ Cash  
☐ MasterCard ☐ Discover ☐ Personal Check

**Average Fee Range:** \$ \_\_\_\_\_ - \$ \_\_\_\_\_

**Special Offers:**

\_\_\_\_\_  
 \_\_\_\_\_

**Correspondence/Communication Preference:**

- ☐ Email Email Address \_\_\_\_\_ ☐ Fax Fax Number \_\_\_\_\_  
☐ United States Postal Service

**PRIMARY LOCATION OFFICE HOURS**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

**SECONDARY LOCATION OFFICE HOURS**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

## **DEFINITIONS**

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN-contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's health care license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

## **TERMS AND CONDITIONS OF PARTICIPATION**

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii), not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.



- 13. Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
- 14. Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
- 15. Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
- 16. Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
- 17. Attorney's Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
- 18. Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
- 19. Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
- 20. Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
- 21. Waiver of Breach.** A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
- 22. Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
- 23. Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
- 24. Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

## **PARTICIPATION REQUIREMENTS**

**Liability/Insurance:** All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

**Practice Experience:** All practitioners are required to have 12 months experience in the credentialed practice specialty.

**Patient Services:** Practitioners must speak fluent English or have access to an interpreter.

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

**Premises Standards:** Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

**Practitioner Licensure Requirements:**

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

## **NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

### **QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have \_\_\_ have not \_\_\_ had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents. I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Title or Designation (DC, LAc, GCFP, etc): \_\_\_\_\_

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**Current Status of Legal Action:**

\_\_\_\_\_ Pending Court Date (if available): \_\_\_\_\_  
 \_\_\_\_\_ Dismissed or Dropped Date: \_\_\_\_\_  
 \_\_\_\_\_ Closed Date: \_\_\_\_\_

**Resolution:**

\_\_\_\_\_ No Payments  
 \_\_\_\_\_ Out of Court Settlement Amount: \$ \_\_\_\_\_  
 \_\_\_\_\_ Judgment or Award Amount: \$ \_\_\_\_\_

Date of Filing: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Professional Liability Insurer: \_\_\_\_\_

Allegation: \_\_\_\_\_

Details of incident including your role, relating events, and patient outcome:

Have you made any changes in your practice as a result of this incident? Attach separate sheet if required.

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print and sign.

**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists ( <b>MD/DO</b> ) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> <b>NDs and DCs</b> need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least one of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPA) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley Method) <input type="checkbox"/> ASPO/Lamaze – Lamaze-Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or <input type="checkbox"/> state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	Documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least one of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doula of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPA) <input type="checkbox"/> National Association of Postpartum Care Services PLUS <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non-clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000



<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork) <b>OR</b> <input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs. training) <b>OR</b> <input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters</b> of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS</b> : <input type="checkbox"/> Documentation of <b>supervised contact hours</b> performing clinical massage: <input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b> <input type="checkbox"/> 250 contact hours required for applicants with 1,000 hour basic massage education that includes clinical assessment, clinical pathology, and clinical charting <b>OR</b> <input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster!" program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC, <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley, CA, <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours of training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day <input type="checkbox"/> Residential Training Retreat offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of Practicum in MBSR (formerly the Internship Program) and/or Teacher Development Intensive in MBSR and/or Supervision in MBSR conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license. <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental bodywork, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000

<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomat, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine(ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) <b>OR</b> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> La Leche League International accredited Leader program <b>OR</b> International Board of Lactation Consultant Examiners (IBLCE)
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT) <b>OR</b> a registered with Yoga Alliance (200/500 hour certifications) <b>OR</b> a nationally certified course or training program <b>OR</b> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility



# FAX

**To:** [REDACTED]

Company:

Fax: 734455 [REDACTED]

Phone:

**From:**

Fax:

Phone:

E-mail: Marcus.LathanPrice@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Tuesday, January 30, 2018 5:40:06 PM  
**Number of pages including this cover sheet:** 15

**Confidential**

**TIV00005058**

My name is Marcus Latham-Price with Tivity Health. My company manages provider relations for WholeHealth Networks in the 50 plus age group.

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a complementary health component, providing members with a \$20 voucher to be applied for services.

In addition, we are extending an invitation to join our Humana program. Humana is a covered acupuncture benefit for Humana Medicare Advantage members, serving 300,000 members.

We invite you to complete the WHN contracting and credentialing process to begin servicing eligible members in your area by following the instructions below:

- The WHN agreement is available at [www.WholeHealthPro.com](http://www.WholeHealthPro.com)
    1. You can print the agreement at:  
<https://www.wholehealthpro.com/Credentialing/GetDocumentByDisplayName?displayName=WHN%20Universal%20Participating%20Practitioner%20Agreement>
    2. Complete, sign and return first page of the Participating Practitioner Agreement and your W-9 for payment information.
    3. Completed documents may be returned to me by email or FAX to 480-393-1769 (if you decide to fax them please indicate my name on the cover page).
  - Credentialing is the next step.
    1. Your application can be completed online at: <https://tivityhealth.providersource.com/>
- For any credentialing questions please contact Medversant at 855-654-3374.

Upon completion of the WHN Credentialing and Application process you will receive a WHN Welcome Letter and additional access to WholeHealthPro.com for more educational and contract information.

If you have any questions regarding the enclosed information, please feel free to contact me at (480) 692-2703 or email me at [marcus.lathamprice@tivityhealth.com](mailto:marcus.lathamprice@tivityhealth.com). We look forward to having you join us our network.



**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between WholeHealth Networks, Inc. ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WHOLEHEALTH NETWORKS, INC.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY**

**Network Status:** Open

**Product Type:** The Health and Fitness Product

**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

**Program Design:**

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
  - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
  - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

**Questions:**

- Customer Service: 1-800-274-7526
- Address Changes: [provider.updates@tivityhealth.com](mailto:provider.updates@tivityhealth.com)
- Voucher redemption: Tivity Health WholeHealth Networks  
1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

Form <b>W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer Identification Number and Certification</b>	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.



Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>3</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>3</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup>List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup>Circle the minor's name and furnish the minor's SSN.

<sup>3</sup>You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup>List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.





20098 Ashbrook Place  
Suite 250, Ashburn, VA 20147  
Phone: 1-800-274-7526  
Fax: 1-888-492-1026  
[Provider.Updates@TivityHealth.com](mailto:Provider.Updates@TivityHealth.com)

**WHOLEHEALTH LIVING® CHOICES NETWORK**  
**PARTICIPATING PRACTITIONER AGREEMENT**  
**CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS**

**INSTRUCTIONS**

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application, please return this application along with the necessary documentation to the address listed at the top of the page.

- ☐ Copy of license(s) if applicable
- ☐ Copy of insurance face sheet for professional and business liability policy
- ☐ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ☐ Signed release and attestation statement, with professional liability form if applicable.

**SIGNATURE LINE**

This Agreement is a contract between WholeHealth Networks, Inc. ("**WHN**"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("**Practitioner**"), (each a "**Party**," and together the "**Parties**") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("**Terms**").

**PRACTITIONER SPECIALTIES**

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acupuncture                     | <input type="checkbox"/> Hellerwork                             | <input type="checkbox"/> Nutritional Counselor                |
| <input type="checkbox"/> Acupuncture, MD/DO              | <input type="checkbox"/> Herbal Consultant                      | <input type="checkbox"/> Occupational Therapist               |
| <input type="checkbox"/> Acupuncture, DC/ND              | <input type="checkbox"/> Holistic Nurse Practitioner            | <input type="checkbox"/> Asian/Oriental Bodywork Therapist    |
| <input type="checkbox"/> Behavioral Health               | <input type="checkbox"/> Homeopathy                             | <input type="checkbox"/> Pain Practitioner                    |
| <input type="checkbox"/> Biofeedback                     | <input type="checkbox"/> Hypnotist, non-clinical                | <input type="checkbox"/> Personal Trainer/Exercise Specialist |
| <input type="checkbox"/> Childbirth Educators            | <input type="checkbox"/> Integrative Holistic Physician (MD/DO) | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Chinese Herbal Medicine         | <input type="checkbox"/> Massage Therapy                        | <input type="checkbox"/> Pilates Instructor                   |
| <input type="checkbox"/> Chiropractic Physician          | <input type="checkbox"/> Massage Therapy – Clinical             | <input type="checkbox"/> Post Birthing & Lactation Counselor  |
| <input type="checkbox"/> Dietician - Registered/Licensed | <input type="checkbox"/> Mind-Body Skills Instructor            | <input type="checkbox"/> Qi Gong Instructor                   |
| <input type="checkbox"/> Doulas                          | <input type="checkbox"/> Mindfulness-Based Stress Reduction     | <input type="checkbox"/> Reflexologist                        |
| <input type="checkbox"/> Energy Healing Practitioner     | <input type="checkbox"/> Teacher                                | <input type="checkbox"/> Tai Chi Instructor                   |
| <input type="checkbox"/> Feldenkrais                     | <input type="checkbox"/> Music Therapy                          | <input type="checkbox"/> Yoga Instructor                      |
| <input type="checkbox"/> Guided Imagery/Hypnotherapy     | <input type="checkbox"/> Naturopathic Physician                 |   |

**DISCOUNT AGREEMENT**

Practitioner will offer Services to Network participants at a discount of \_\_\_\_\_% (minimum of 10%-30%) to all of Practitioner's usual charges for Services (the "**Discount**"). If the Discount is left blank, Practitioner will provide a **20% Discount**. **Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.**

This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("**Effective Date**"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least **90 days (30 days for Practitioners in Illinois)** prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Accepted by: Martie Stabelfeldt, VP, WholeHealth Living

\_\_\_\_\_  
Date

<b>Primary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____ Office Fax: _____
Office Contact:	_____ Title: _____
Website Address:	E-Mail: _____
<b>Secondary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____ Office Fax: _____
Office Contact:	_____ Title: _____
Website Address:	E-Mail Address: _____

\* If you have additional locations, please list them on a separate sheet.

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_

Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_

Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_

Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_

Do you wish to have your Website listed on your profile? \_\_\_\_\_

What is your first year of practice? \_\_\_\_\_

What non-English languages do you or your office staff speak fluently? Please list \_\_\_\_\_

**Practice Focus:**

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**Payment Methods Accepted:**

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Visa       | <input type="checkbox"/> American Express | <input type="checkbox"/> Cash           |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover         | <input type="checkbox"/> Personal Check |

**Average Fee Range:** \$ \_\_\_\_\_ - \$ \_\_\_\_\_

**Special Offers:**

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**Correspondence/Communication Preference:**

- ☐ Email Email Address \_\_\_\_\_
- ☐ Fax Fax Number \_\_\_\_\_
- ☐ United States Postal Service

PRIMARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM
SECONDARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM

**DEFINITIONS**

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN- contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's healthcare license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

**TERMS AND CONDITIONS OF PARTICIPATION**

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-Discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii) not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants.

13. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
14. **Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
15. **Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
16. **Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
17. **Attorney's Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
18. **Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
19. **Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
20. **Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
21. **Waiver of Breach.** A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
22. **Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
23. **Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
24. **Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

#### **PARTICIPATION REQUIREMENTS**

**Liability/Insurance:** All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

**Practice Experience:** All practitioners are required to have 12 months experience in the credentialed practice specialty.

**Patient Services:** Practitioners must speak fluent English or have access to an interpreter.

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

**Premises Standards:** Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

**Practitioner Licensure Requirements:**

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

#### **NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

##### **QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have \_\_, have not \_\_ had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents.

I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Title or Designation (DC, LAc, GCFP, etc): \_\_\_\_\_

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**Current status of legal action:**

\_\_\_\_\_ Pending Court Date (if available): \_\_\_\_\_  
 \_\_\_\_\_ Dismissed or Dropped Date: \_\_\_\_\_  
 \_\_\_\_\_ Closed Date: \_\_\_\_\_

**Resolution:**

\_\_\_\_\_ No Payments  
 \_\_\_\_\_ Out of Court Settlement Amount: \$ \_\_\_\_\_  
 \_\_\_\_\_ Judgment or Award Amount: \$ \_\_\_\_\_

Date of Filing: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Professional Liability Insurer: \_\_\_\_\_

**Allegation:**

\_\_\_\_\_

**Details of incident including your role, relating events, and patient outcome:**

\_\_\_\_\_

**Have you made any changes in your practice as a result of this incident? Attach separate sheet if required.**

\_\_\_\_\_

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

*Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.*

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists (MD/DO) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> NDs and DCs need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley® Method) <input type="checkbox"/> ASPQ/Lamaze – Lamaze Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	Documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doulas of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> National Association of Postpartum Care Services <b>PLUS</b> <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork) <b>OR</b> <input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) <b>OR</b> <input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters of Reference</b> from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS</b> : <input type="checkbox"/> Documentation of <b>supervised contact hours</b> performing clinical massage: <input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b> <input type="checkbox"/> 250 contact hours required for applicants with 1000 hour basic massage education that includes clinical assessment, clinical pathology, and clinical charting <b>OR</b>

	<input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley, CA <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours of training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of <i>Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat</i> offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of <i>Practicum in MBSR</i> (formerly the <i>Internship Program</i> ) and/or <i>Teacher Development Intensive in MBSR</i> and/or <i>Supervision in MBSR</i> conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomate, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine (ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) <b>OR</b> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	<input type="checkbox"/> A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> <input type="checkbox"/> La Leche League International accredited Leader program <b>OR</b> International Board of Lactation Consultant Examiners (IBLCE)
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT) <b>OR</b> a registered with Yoga Alliance (200/500 hour certifications) <b>OR</b> a nationally certified course or training program <b>OR</b> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility

# FAX

**To:** [REDACTED]  
Company:  
Fax: 1212765 [REDACTED]  
Phone:

**From:**  
Fax:  
Phone:  
E-mail: Jazmin.Walker@tivityhealth.com

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## NOTES:

[REDACTED]

My name is Jaz with Tivity Health, a National Network Manager. We have partnered with Aetna & Humana to recruit quality practitioners such as yourself, to be a Preferred Provider in your area. I have included details about our program. It doesn't seem to be too cumbersome, but if you come up with any questions or concerns, please don't hesitate to me contact me via email or by phone. I am in the office from 6:30 am to 3:00 pm MST M-F. If by chance I do not here from you, I will reach out to you in about a week. Have a great day!

Best Regards,

Jaz Walker Recruiter  
Tivity Health tivityhealth.com  
o 480.692.2719 f 480.393.1769 a 1445 S. Spectrum Blvd.,  
Chandler, AZ 85286  
Jazmin.Walker@tivityhealth.com

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**Date and time of transmission:** Tuesday, March 20, 2018 11:25:44 AM  
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Form <b>W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer Identification Number and Certification</b>	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign  
Here**

 Signature of  
U.S. person ▶

Date ▶

**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 8045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.



**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>3</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>3</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



20098 Ashbrook Place  
Suite 250, Ashburn, VA 20147  
Phone: 1-800-274-7526  
Fax: 1-888-492-1026  
[Provider.Updates@TivityHealth.com](mailto:Provider.Updates@TivityHealth.com)

**WHOLEHEALTH LIVING® CHOICES NETWORK**  
**PARTICIPATING PRACTITIONER AGREEMENT**  
**CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS**

**INSTRUCTIONS**

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application, please return this application along with the necessary documentation to the address listed at the top of the page.

- ☐ Copy of license(s) if applicable
- ☐ Copy of insurance face sheet for professional and business liability policy
- ☐ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ☐ Signed release and attestation statement, with professional liability form if applicable.

**SIGNATURE LINE**

This Agreement is a contract between WholeHealth Networks, Inc. ("WHN"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("Practitioner"), (each a "Party," and together the "Parties") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("Terms").

**PRACTITIONER SPECIALTIES**

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acupuncture                     | <input type="checkbox"/> Hellerwork                             | <input type="checkbox"/> Nutritional Counselor                |
| <input type="checkbox"/> Acupuncture, MD/DO              | <input type="checkbox"/> Herbal Consultant                      | <input type="checkbox"/> Occupational Therapist               |
| <input type="checkbox"/> Acupuncture, DC/ND              | <input type="checkbox"/> Holistic Nurse Practitioner            | <input type="checkbox"/> Asian/Oriental Bodywork Therapist    |
| <input type="checkbox"/> Behavioral Health               | <input type="checkbox"/> Homeopathy                             | <input type="checkbox"/> Pain Practitioner                    |
| <input type="checkbox"/> Biofeedback                     | <input type="checkbox"/> Hypnotist, non-clinical                | <input type="checkbox"/> Personal Trainer/Exercise Specialist |
| <input type="checkbox"/> Childbirth Educators            | <input type="checkbox"/> Integrative Holistic Physician (MD/DO) | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Chinese Herbal Medicine         | <input type="checkbox"/> Massage Therapy                        | <input type="checkbox"/> Pilates Instructor                   |
| <input type="checkbox"/> Chiropractic Physician          | <input type="checkbox"/> Massage Therapy – Clinical             | <input type="checkbox"/> Post Birthing & Lactation Counselor  |
| <input type="checkbox"/> Dietician - Registered/Licensed | <input type="checkbox"/> Mind-Body Skills Instructor            | <input type="checkbox"/> Qi Gong Instructor                   |
| <input type="checkbox"/> Doulas                          | <input type="checkbox"/> Mindfulness-Based Stress Reduction     | <input type="checkbox"/> Reflexologist                        |
| <input type="checkbox"/> Energy Healing Practitioner     | <input type="checkbox"/> Teacher                                | <input type="checkbox"/> Tai Chi Instructor                   |
| <input type="checkbox"/> Feldenkrais                     | <input type="checkbox"/> Music Therapy                          | <input type="checkbox"/> Yoga Instructor                      |
| <input type="checkbox"/> Guided Imagery/Hypnotherapy     | <input type="checkbox"/> Naturopathic Physician                 |   |

**DISCOUNT AGREEMENT**

Practitioner will offer Services to Network participants at a discount of \_\_\_\_\_% (minimum of 10%-30%) to all of Practitioner's usual charges for Services (the "Discount"). If the Discount is left blank, Practitioner will provide a **20% Discount**. **Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.**

This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("Effective Date"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least **90 days (30 days for Practitioners in Illinois)** prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Accepted by: Martie Stabelfeldt, VP, WholeHealth Living

\_\_\_\_\_  
Date

<b>Primary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Office Contact:	_____
Website Address:	_____
Office Fax:	_____
Title:	_____
E-Mail:	_____
<b>Secondary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Office Contact:	_____
Website Address:	_____
Office Fax:	_____
Title:	_____
E-Mail Address:	_____

\* If you have additional locations, please list them on a separate sheet.

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_

Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_

Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_

Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_

Do you wish to have your Website listed on your profile? \_\_\_\_\_

What is your first year of practice? \_\_\_\_\_

What non-English languages do you or your office staff speak fluently? Please list \_\_\_\_\_

**Practice Focus:**

**Payment Methods Accepted:**

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Visa       | <input type="checkbox"/> American Express | <input type="checkbox"/> Cash           |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover         | <input type="checkbox"/> Personal Check |

Average Fee Range: \$ \_\_\_\_\_ - \$ \_\_\_\_\_

Special Offers:

**Correspondence/Communication Preference:**

- ☐ Email Email Address \_\_\_\_\_
- ☐ Fax Fax Number \_\_\_\_\_
- ☐ United States Postal Service

PRIMARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM
SECONDARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM



**DEFINITIONS**

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN- contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's healthcare license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

**TERMS AND CONDITIONS OF PARTICIPATION**

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-Discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii), not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants.

13. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
14. **Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
15. **Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
16. **Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
17. **Attorney's Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
18. **Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
19. **Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
20. **Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
21. **Waiver of Breach.** A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
22. **Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
23. **Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
24. **Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

#### **PARTICIPATION REQUIREMENTS**

**Liability/Insurance:** All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

**Practice Experience:** All practitioners are required to have 12 months experience in the credentialed practice specialty.

**Patient Services:** Practitioners must speak fluent English or have access to an interpreter.

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

**Premises Standards:** Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

**Practitioner Licensure Requirements:**

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

#### **NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

##### **QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.



**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have ☐ have not ☐ had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents.

I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Title or Designation (DC, LAc, GCFP, etc): \_\_\_\_\_

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**Current status of legal action:**

☐ Pending Court Date (if available): \_\_\_\_\_  
☐ Dismissed or Dropped Date: \_\_\_\_\_  
☐ Closed Date: \_\_\_\_\_

**Resolution:**

☐ No Payments  
☐ Out of Court Settlement Amount: \$ \_\_\_\_\_  
☐ Judgment or Award Amount: \$ \_\_\_\_\_

Date of Filing: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Professional Liability Insurer: \_\_\_\_\_

Allegation: \_\_\_\_\_

Details of incident including your role, relating events, and patient outcome: \_\_\_\_\_

Have you made any changes in your practice as a result of this incident? Attach separate sheet if required. \_\_\_\_\_

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

*Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.*

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists ( <b>MD/DO</b> ) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> <b>NDs and DCs</b> need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley ® Method) <input type="checkbox"/> ASPQ/Lamaze – Lamaze Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	Documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doulas of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> National Association of Postpartum Care Services <b>PLUS</b> <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork <b>OR</b> <input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) <b>OR</b> <input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBTMB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters</b> of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS:</b> <input type="checkbox"/> Documentation of <u>supervised contact hours</u> performing clinical massage: <input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b> <input type="checkbox"/> 250 contact hours required for applicants with 1000 hour basic massage education that includes clinical assessment, clinical pathology, and clinical charting <b>OR</b>

	<input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley, CA <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours of training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of <i>Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat</i> offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of <i>Practicum in MBSR</i> (formerly the <i>Internship Program</i> ) and/or <i>Teacher Development Intensive in MBSR</i> and/or <i>Supervision in MBSR</i> conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomate, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine (ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) <b>OR</b> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	<input type="checkbox"/> A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> <input type="checkbox"/> La Leche League International accredited Leader program <b>OR</b> International Board of Lactation Consultant Examiners (IBLCE)
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT) <b>OR</b> a registered with Yoga Alliance (200/500 hour certifications) <b>OR</b> a nationally certified course or training program <b>OR</b> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility





**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**WHOLEHEALTH NETWORKS, INC.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

WHN Choices Voucher Amendment 1.7.2018

**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY**

**Network Status:** Open

**Product Type:** The Health and Fitness Product

**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

**Program Design:**

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
  - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
  - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

**Questions:**

- Customer Service: 1-800-274-7526
- Address Changes: [provider.updates@tivityhealth.com](mailto:provider.updates@tivityhealth.com)
- Voucher redemption: Tivity Health WholeHealth Networks  
1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

# FAX

**To:** [REDACTED]

Company:

Fax: 1845501 [REDACTED]

Phone:

**From:**

Fax:

Phone:

E-mail: Jazmin.Walker@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Tuesday, April 10, 2018 12:15:40 PM  
**Number of pages including this cover sheet:** 02



1445 S. Spectrum Blvd., Chandler, AZ 85286

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a complementary health component, providing members with a \$20 voucher to be applied for services. The first voucher is not redeemable, and every voucher thereafter is redeemable. **We hope you consider joining today!**

If you are interested in joining, I can forward you the appropriate contracts via email or you can complete the application online at <https://www.wholehealthpro.com/>

WHOLE HEALTH PRO

HOME FEATURES PROGRAMS CREDENTIALING CONTACT US REGISTER

LOGIN

Announcements

- Grow your business! Click here to get started: [WholeHealth Living Network Application](#)
- View an introductory overview of the new features: [Educational Reference](#)
- Navigate back to the old WholeHealth Pro site: [Legacy WholeHealth Pro Portal](#)

A secure online resource portal  
for our participating practitioners.

A convenient way for our practitioners to conduct daily office operations.

Access to the WHN authorization web portal

View the WHN Provider Manual

Claims address lookup

View Participating Health Plan group summaries and fee schedules

Obtain credentialing information

Download clinical documents

Best Regards,

**Jaz Walker • Recruiter**

**Tivity Health • [tivityhealth.com](http://tivityhealth.com)**

**o • 480.692.2719 f • 480.383.6409 a • 1445 S. Spectrum Blvd., Chandler, AZ 85286**

**[Jazmin.Walker@tivityhealth.com](mailto:Jazmin.Walker@tivityhealth.com)**

Confidential

TIV00007376



# FAX

**To:** [REDACTED]  
**Company:**  
**Fax:** 512778 [REDACTED]  
**Phone:**

**From:**  
**Fax:**  
**Phone:**  
**E-mail:** Zachary.Williams@tivityhealth.com

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## NOTES:

[REDACTED]

I'm Zachary Williams with Tivity Health and my company manages provider relations for Whole Health Networks in the 50+ age group. I'm reaching out today because WHN is currently enrolling to their 2018 Network, and I would like to invite you to join the network! We're currently offering this opportunity to Chiropractors, Massage Therapist and Acupuncturist.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years.

This is a great opportunity to help the 50 plus age group in your area and enhancing the expansion of your business. If this is something that interests you, please follow the steps below. This product will have a complementary health component, providing members with a \$20 voucher to be applied for services.

I have also attached the Contract, W-9 and Group Summary for your review. Completed documents may be returned to me via Email at Zachary.Williams@tivityhealth.com or fax 480-393-1769 if you decide

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**Date and time of transmission:** Wednesday, January 31, 2018 10:52:00 AM  
**Number of pages including this cover sheet:** 14



**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between WholeHealth Networks, Inc. ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**WHOLEHEALTH NETWORKS, INC.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY**

**Network Status:** Open

**Product Type:** The Health and Fitness Product

**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

**Program Design:**

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
  - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
  - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

**Questions:**

- Customer Service: 1-800-274-7526
- Address Changes: [provider.updates@tivityhealth.com](mailto:provider.updates@tivityhealth.com)
- Voucher redemption: Tivity Health WholeHealth Networks  
1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

<b>Form W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer Identification Number and Certification</b>	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign  
Here**

 Signature of  
U.S. person ▶

Date ▶

**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.



**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup>List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup>Circle the minor's name and furnish the minor's SSN.

<sup>3</sup>You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup>List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

#### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



20098 Ashbrook Place  
Suite 250, Ashburn, VA 20147  
Phone: 1-800-274-7526  
Fax: 1-888-492-1026  
[Provider.Updates@TivityHealth.com](mailto:Provider.Updates@TivityHealth.com)

**WHOLEHEALTH LIVING® CHOICES NETWORK**  
**PARTICIPATING PRACTITIONER AGREEMENT**  
**CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS**

**INSTRUCTIONS**

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application, please return this application along with the necessary documentation to the address listed at the top of the page.

- ☐ Copy of license(s) if applicable
- ☐ Copy of insurance face sheet for professional and business liability policy
- ☐ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ☐ Signed release and attestation statement, with professional liability form if applicable.

**SIGNATURE LINE**

This Agreement is a contract between WholeHealth Networks, Inc. ("WHN"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("Practitioner"), (each a "Party," and together the "Parties") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("Terms").

**PRACTITIONER SPECIALTIES**

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acupuncture                     | <input type="checkbox"/> Hellerwork                             | <input type="checkbox"/> Nutritional Counselor                |
| <input type="checkbox"/> Acupuncture, MD/DO              | <input type="checkbox"/> Herbal Consultant                      | <input type="checkbox"/> Occupational Therapist               |
| <input type="checkbox"/> Acupuncture, DC/ND              | <input type="checkbox"/> Holistic Nurse Practitioner            | <input type="checkbox"/> Asian/Oriental Bodywork Therapist    |
| <input type="checkbox"/> Behavioral Health               | <input type="checkbox"/> Homeopathy                             | <input type="checkbox"/> Pain Practitioner                    |
| <input type="checkbox"/> Biofeedback                     | <input type="checkbox"/> Hypnotist, non-clinical                | <input type="checkbox"/> Personal Trainer/Exercise Specialist |
| <input type="checkbox"/> Childbirth Educators            | <input type="checkbox"/> Integrative Holistic Physician (MD/DO) | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Chinese Herbal Medicine         | <input type="checkbox"/> Massage Therapy                        | <input type="checkbox"/> Pilates Instructor                   |
| <input type="checkbox"/> Chiropractic Physician          | <input type="checkbox"/> Massage Therapy – Clinical             | <input type="checkbox"/> Post Birthing & Lactation Counselor  |
| <input type="checkbox"/> Dietician - Registered/Licensed | <input type="checkbox"/> Mind-Body Skills Instructor            | <input type="checkbox"/> Qi Gong Instructor                   |
| <input type="checkbox"/> Doulas                          | <input type="checkbox"/> Mindfulness-Based Stress Reduction     | <input type="checkbox"/> Reflexologist                        |
| <input type="checkbox"/> Energy Healing Practitioner     | <input type="checkbox"/> Teacher                                | <input type="checkbox"/> Tai Chi Instructor                   |
| <input type="checkbox"/> Feldenkrais                     | <input type="checkbox"/> Music Therapy                          | <input type="checkbox"/> Yoga Instructor                      |
| <input type="checkbox"/> Guided Imagery/Hypnotherapy     | <input type="checkbox"/> Naturopathic Physician                 |   |

**DISCOUNT AGREEMENT**

Practitioner will offer Services to Network participants at a discount of \_\_\_\_\_% (minimum of 10%-30%) to all of Practitioner's usual charges for Services (the "Discount"). If the Discount is left blank, Practitioner will provide a **20% Discount**. **Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.**

This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("Effective Date"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least **90 days (30 days for Practitioners in Illinois)** prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Accepted by: Martie Stabelfeldt, VP, WholeHealth Living

\_\_\_\_\_  
Date

<b>Primary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Office Contact:	_____
Website Address:	_____
Office Fax:	_____
Title:	_____
E-Mail:	_____
<b>Secondary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Office Contact:	_____
Website Address:	_____
E-Mail Address:	_____

\* If you have additional locations, please list them on a separate sheet.

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_

Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_

Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_

Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_

Do you wish to have your Website listed on your profile? \_\_\_\_\_

What is your first year of practice? \_\_\_\_\_

What non-English languages do you or your office staff speak fluently? Please list \_\_\_\_\_

**Practice Focus:**

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**Payment Methods Accepted:**

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Visa       | <input type="checkbox"/> American Express | <input type="checkbox"/> Cash           |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover         | <input type="checkbox"/> Personal Check |

**Average Fee Range:**     \$ \_\_\_\_\_ - \$ \_\_\_\_\_

**Special Offers:**

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**Correspondence/Communication Preference:**

- ☐ Email     Email Address \_\_\_\_\_
- ☐ Fax     Fax Number \_\_\_\_\_
- ☐ United States Postal Service

PRIMARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM
SECONDARY LOCATION OFFICE HOURS					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM

**DEFINITIONS**

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN- contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's healthcare license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

**TERMS AND CONDITIONS OF PARTICIPATION**

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-Discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii) not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants.

13. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
14. **Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
15. **Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
16. **Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
17. **Attorney's Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
18. **Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
19. **Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
20. **Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
21. **Waiver of Breach.** A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
22. **Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
23. **Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
24. **Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

#### **PARTICIPATION REQUIREMENTS**

**Liability/Insurance:** All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

**Practice Experience:** All practitioners are required to have 12 months experience in the credentialed practice specialty.

**Patient Services:** Practitioners must speak fluent English or have access to an interpreter.

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

**Premises Standards:** Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

**Practitioner Licensure Requirements:**

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

#### **NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

##### **QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have \_\_, have not \_\_ had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents.

I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Title or Designation (DC, LAc, GCFP, etc): \_\_\_\_\_

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**Current status of legal action:**

_____ Pending	Court Date (if available): _____
_____ Dismissed or Dropped	Date: _____
_____ Closed	Date: _____

**Resolution:**

_____ No Payments	
_____ Out of Court Settlement	Amount: \$ _____
_____ Judgment or Award	Amount: \$ _____

Date of Filing: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Professional Liability Insurer: \_\_\_\_\_

Allegation: \_\_\_\_\_

Details of incident including your role, relating events, and patient outcome: \_\_\_\_\_

Have you made any changes in your practice as a result of this incident? Attach separate sheet if required. \_\_\_\_\_

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

*Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.*

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists ( <b>MD/DO</b> ) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> <b>NDs and DCs</b> need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	<p>Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least <b>one</b> of the following programs:</p> <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley® Method) <input type="checkbox"/> ASPO/Lamaze – Lamaze Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	<p>Documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least <b>one</b> of the following programs:</p> <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doulas of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> National Association of Postpartum Care Services <b>PLUS</b> <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <ul style="list-style-type: none"> <li><input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage &amp; Bodywork) <b>OR</b></li> <li><input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) <b>OR</b></li> <li><input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.)</li> </ul> <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters</b> of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Documentation of <b>supervised contact hours</b> performing clinical massage: <ul style="list-style-type: none"> <li><input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b></li> <li><input type="checkbox"/> 250 contact hours required for applicants with 1000 hour basic massage education that includes clinical assessment, clinical pathology, and clinical charting <b>OR</b></li> </ul> </li> </ul>

	<input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley, CA <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation Instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours of training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of <i>Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat</i> offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of <i>Practicum in MBSR</i> (formerly the <i>Internship Program</i> ) and/or <i>Teacher Development Intensive in MBSR</i> and/or <i>Supervision in MBSR</i> conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomate, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine (ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) <b>OR</b> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	<input type="checkbox"/> A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> <input type="checkbox"/> La Leche League International accredited Leader program <b>OR</b> International Board of Lactation Consultant Examiners (IBLCE)
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT) <b>OR</b> a registered with Yoga Alliance (200/500 hour certifications) <b>OR</b> a nationally certified course or training program <b>OR</b> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility

# FAX

**To:** [REDACTED]

Company:

Fax: 845353 [REDACTED]

Phone:

**From:**

Fax:

Phone:

E-mail: Bryant.Babino@tivityhealth.com

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## NOTES:

Voucher Program to provide service to our exhistig data base.

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**Date and time of transmission:** Wednesday, April 18, 2018 4:21:06 PM  
**Number of pages including this cover sheet:** 14

Form (Rev. October 2007) Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Request for Taxpayer Identification Number and Certification</h2>	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

### Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

#### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.



**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>3</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



20098 Ashbrook Place  
Suite 250, Ashburn, VA 20147  
Phone: 1-800-274-7526  
Fax: 1-888-492-1026  
[Provider.Updates@TivityHealth.com](mailto:Provider.Updates@TivityHealth.com)

**WHOLEHEALTH LIVING® CHOICES NETWORK**  
**PARTICIPATING PRACTITIONER AGREEMENT**  
**CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS**

**INSTRUCTIONS**

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application, please return this application along with the necessary documentation to the address listed at the top of the page.

- ☐ Copy of license(s) if applicable
- ☐ Copy of insurance face sheet for professional and business liability policy
- ☐ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ☐ Signed release and attestation statement, with professional liability form if applicable.

**SIGNATURE LINE**

This Agreement is a contract between WholeHealth Networks, Inc. ("WHN"), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner ("Practitioner"), (each a "Party," and together the "Parties") and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 ("Terms").

**PRACTITIONER SPECIALTIES**

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acupuncture                     | <input type="checkbox"/> Hellerwork                             | <input type="checkbox"/> Nutritional Counselor                |
| <input type="checkbox"/> Acupuncture, MD/DO              | <input type="checkbox"/> Herbal Consultant                      | <input type="checkbox"/> Occupational Therapist               |
| <input type="checkbox"/> Acupuncture, DC/ND              | <input type="checkbox"/> Holistic Nurse Practitioner            | <input type="checkbox"/> Asian/Oriental Bodywork Therapist    |
| <input type="checkbox"/> Behavioral Health               | <input type="checkbox"/> Homeopathy                             | <input type="checkbox"/> Pain Practitioner                    |
| <input type="checkbox"/> Biofeedback                     | <input type="checkbox"/> Hypnotist, non-clinical                | <input type="checkbox"/> Personal Trainer/Exercise Specialist |
| <input type="checkbox"/> Childbirth Educators            | <input type="checkbox"/> Integrative Holistic Physician (MD/DO) | <input type="checkbox"/> Physical Therapy                     |
| <input type="checkbox"/> Chinese Herbal Medicine         | <input type="checkbox"/> Massage Therapy                        | <input type="checkbox"/> Pilates Instructor                   |
| <input type="checkbox"/> Chiropractic Physician          | <input type="checkbox"/> Massage Therapy – Clinical             | <input type="checkbox"/> Post Birthing & Lactation Counselor  |
| <input type="checkbox"/> Dietician - Registered/Licensed | <input type="checkbox"/> Mind-Body Skills Instructor            | <input type="checkbox"/> Qi Gong Instructor                   |
| <input type="checkbox"/> Doulas                          | <input type="checkbox"/> Mindfulness-Based Stress Reduction     | <input type="checkbox"/> Reflexologist                        |
| <input type="checkbox"/> Energy Healing Practitioner     | <input type="checkbox"/> Teacher                                | <input type="checkbox"/> Tai Chi Instructor                   |
| <input type="checkbox"/> Feldenkrais                     | <input type="checkbox"/> Music Therapy                          | <input type="checkbox"/> Yoga Instructor                      |
| <input type="checkbox"/> Guided Imagery/Hypnotherapy     | <input type="checkbox"/> Naturopathic Physician                 |   |

**DISCOUNT AGREEMENT**

Practitioner will offer Services to Network participants at a discount of \_\_\_\_\_% (minimum of 10%-30%) to all of Practitioner's usual charges for Services (the "Discount"). If the Discount is left blank, Practitioner will provide a **20% Discount**. **Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.**

This Agreement and the Discount are effective on the date that Practitioner signs this Agreement ("Effective Date"). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least **90 days (30 days for Practitioners in Illinois)** prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner's Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Accepted by: Martie Stabelfeldt, VP, WholeHealth Living

\_\_\_\_\_  
Date

<b>Primary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____ Office Fax: _____
Office Contact:	_____ Title: _____
Website Address:	E-Mail: _____
<b>Secondary Location:</b>	
Clinic Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____ Office Fax: _____
Office Contact:	_____ Title: _____
Website Address:	E-Mail Address: _____

\* If you have additional locations, please list them on a separate sheet.

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_

Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_

Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_

Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_

Do you wish to have your Website listed on your profile? \_\_\_\_\_

What is your first year of practice? \_\_\_\_\_

What non-English languages do you or your office staff speak fluently? Please list \_\_\_\_\_

**Practice Focus:**

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**Payment Methods Accepted:**

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Visa       | <input type="checkbox"/> American Express | <input type="checkbox"/> Cash           |
| <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover         | <input type="checkbox"/> Personal Check |

Average Fee Range: \$ \_\_\_\_\_ - \$ \_\_\_\_\_

Special Offers:

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**Correspondence/Communication Preference:**

- ☐ Email Email Address \_\_\_\_\_
- ☐ Fax Fax Number \_\_\_\_\_
- ☐ United States Postal Service

PRIMARY LOCATION OFFICE HOURS						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM
SECONDARY LOCATION OFFICE HOURS						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM



**DEFINITIONS**

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN- contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's healthcare license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

**TERMS AND CONDITIONS OF PARTICIPATION**

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-Discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii), not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants.

13. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.
14. **Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
15. **Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
16. **Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
17. **Attorney's Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator's decision, fails to comply with the arbitrator's decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys' fees.
18. **Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
19. **Notices.** The Parties agree that all notices shall be sent to a Party's address as provided on the first page of this Agreement.
20. **Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner's performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
21. **Waiver of Breach.** A Party's waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
22. **Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties' course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
23. **Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
24. **Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

#### **PARTICIPATION REQUIREMENTS**

**Liability/Insurance:** All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD's and DO's, as well as ND's and DC's who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called "nose" or "tail" policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

**Practice Experience:** All practitioners are required to have 12 months experience in the credentialed practice specialty.

**Patient Services:** Practitioners must speak fluent English or have access to an interpreter.

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

Practitioner agrees that practitioner's practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner's practice.

**Premises Standards:** Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

**Practitioner Licensure Requirements:**

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

#### **NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

##### **QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner's healthcare license is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have   , have not    had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents.

I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_ Title or Designation (DC, LAc, GCFP, etc): \_\_\_\_\_

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

Practitioner Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

**Current status of legal action:**

\_\_\_\_\_ Pending Court Date (if available): \_\_\_\_\_  
 \_\_\_\_\_ Dismissed or Dropped Date: \_\_\_\_\_  
 \_\_\_\_\_ Closed Date: \_\_\_\_\_

**Resolution:**

\_\_\_\_\_ No Payments  
 \_\_\_\_\_ Out of Court Settlement Amount: \$ \_\_\_\_\_  
 \_\_\_\_\_ Judgment or Award Amount: \$ \_\_\_\_\_

Date of Filing: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Professional Liability Insurer: \_\_\_\_\_

Allegation: \_\_\_\_\_

Details of incident including your role, relating events, and patient outcome: \_\_\_\_\_

Have you made any changes in your practice as a result of this incident? Attach separate sheet if required. \_\_\_\_\_

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

*Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.*

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists ( <b>MD/DO</b> ) must hold a valid unrestricted license to practice medicine including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> <b>NDs and DCs</b> need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley ® Method) <input type="checkbox"/> ASPQ/Lamaze – Lamaze Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	Documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doulas of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPPa) <input type="checkbox"/> National Association of Postpartum Care Services <b>PLUS</b> <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork <b>OR</b> <input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) <b>OR</b> <input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBTMB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters</b> of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS:</b> <input type="checkbox"/> Documentation of <u>supervised contact hours</u> performing clinical massage: <input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b> <input type="checkbox"/> 250 contact hours required for applicants with 1000 hour basic massage education that includes clinical assessment, clinical pathology, and clinical charting <b>OR</b>

	<input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley, CA <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours of training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of <i>Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat</i> offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of <i>Practicum in MBSR</i> (formerly the <i>Internship Program</i> ) and/or <i>Teacher Development Intensive in MBSR</i> and/or <i>Supervision in MBSR</i> conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomate, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine (ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) <b>OR</b> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	<input type="checkbox"/> A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of: <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> <input type="checkbox"/> La Leche League International accredited Leader program <b>OR</b> International Board of Lactation Consultant Examiners (IBLCE)
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT) <b>OR</b> a registered with Yoga Alliance (200/500 hour certifications) <b>OR</b> a nationally certified course or training program <b>OR</b> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility



**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**WHOLEHEALTH NETWORKS, INC.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

WHN Choices Voucher Amendment 1.7.2018

**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY**

**Network Status:** Open

**Product Type:** The Health and Fitness Product

**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

**Program Design:**

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
  - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
  - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

**Questions:**

- Customer Service: 1-800-274-7526
- Address Changes: [provider.updates@tivityhealth.com](mailto:provider.updates@tivityhealth.com)
- Voucher redemption: Tivity Health WholeHealth Networks  
1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>



# FAX

**To:** [REDACTED]  
**Company:**  
**Fax:** 410680 [REDACTED]  
**Phone:**

**From:**  
**Fax:**  
**Phone:**  
**E-mail:** Bryant.Babino@tivityhealth.com

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## NOTES:

Hi [REDACTED]

Just complete these forms. Fax them to me today and then you need to credential. Instrcutions for credentialing are in the email I sent to your OM, but if you need just let me know.

Bryant Babino  
Tivity Health WHN  
480 692 2704

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**Date and time of transmission:** Thursday, May 24, 2018 4:15:10 PM  
**Number of pages including this cover sheet:** 08



**WHOLEHEALTH NETWORKS INC. PARTICIPATING PRACTITIONER AGREEMENT  
CERTIFICATE OF PARTICIPATION  
FOR  
COVERED BENEFIT AND WHOLEHEALTH LIVING® CHOICES PROGRAMS**

I, \_\_\_\_\_, ("PRACTITIONER"), hereby tender this Certificate of Participation in WholeHealth Networks, Inc (WHN) upon the terms and conditions set forth in the attached WHN Participating Practitioner Agreement and to serve as a Participating Provider for the Group benefit plans contracted on my behalf by WHN. I hereby agree to the Terms and Conditions of this Agreement. I hereby agree to extend a \_\_\_\_\_ % (minimum of 10%) discount from my published fee schedule to all WHN Choices Program Participants (see page two for definition of Choices Program). If the above area is left blank, WHN will assume and Practitioner agrees a 20% discount will be extended to all Choices Program members.

I authorize WHN, a subsidiary of Tivity Health Support, LLC, to consult with past employers, malpractice carriers regarding claims history and limitations, educational institutions regarding graduation, and any other persons to obtain and verify my credentials and qualifications as a Practitioner. I release WHN and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application. I consent to the release by any person to WHN all information that may reasonably be relevant to an evaluation of my professional competency, character, moral and ethical qualifications, including any information relating to any disciplinary action; suspension, refusal, restriction or revocation of state license; and hereby release any such person providing such information from any and all liability from doing so.

\_\_\_\_\_  
Practitioner's Printed Name

\_\_\_\_\_  
Licensed Specialty or Specialties

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

<b>Primary Location:</b>		<b>Group NPI:</b>
Address:		
City, State, Zip:		
Phone:	Fax:	Tax ID:
<b>Secondary Location:</b>		<b>Group NPI:</b>
Address:		
City, State, Zip:		
Phone:	Fax:	Tax ID:
<b>Individual NPI:</b>	<b>License Number:</b>	<b>Expiration Date:</b>
<b>Malpractice Carrier:</b>	<b>Malpractice Limits:</b>	<b>Expiration Date:</b>
<b>Medicare Number:</b>	<b>Medicaid Number:</b>	

**Email Address:** \_\_\_\_\_ **Average Fee Range:** \$ \_\_\_\_\_-\$ \_\_\_\_\_

**Payment Methods Accepted:** \_\_\_\_\_ Credit Cards \_\_\_\_\_ Cash \_\_\_\_\_ Personal Check \_\_\_\_\_ Debit Cards

\*\*\*\*\*

**NOTE:** In order to participate in WholeHealth Network's covered benefits participation agreements, you must return a fully completed and signed copy of this cover page.



Form <b>W-9</b> (Rev. October 2007) Department of the Treasury Internal Revenue Service	<b>Request for Taxpayer Identification Number and Certification</b>	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ----- <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**General Instructions**

Section references are to the Internal Revenue Code unless otherwise noted.

**Purpose of Form**

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt payees 1 through 7 <sup>2</sup>

<sup>1</sup>See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup>However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.ssa.gov](http://www.ssa.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or disregarded entity owned by an individual	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

### Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to [phishing@irs.gov](mailto:phishing@irs.gov). You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: [spam@uce.gov](mailto:spam@uce.gov) or contact them at [www.consumer.gov/idtheft](http://www.consumer.gov/idtheft) or 1-877-IDTHEFT(438-4338).

Visit the IRS website at [www.irs.gov](http://www.irs.gov) to learn more about identity theft and how to reduce your risk.

### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.





**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY****Network Status:** Open**Product Type:** The Health and Fitness Product**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists**Program Design:**

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
  - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
  - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

**Questions:**

- Customer Service: 1-800-274-7526
- Address Changes: provider.updates@tivityhealth.com
- Voucher redemption: Tivity Health WholeHealth Networks  
1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

WHN Choices Voucher Amendment 2.19.2018



# FAX

**To:** [REDACTED]  
Company:  
Fax: 410680 [REDACTED]  
Phone:

**From:**  
Fax:  
Phone:  
E-mail: Bryant.Babino@tivityhealth.com

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**NOTES:**

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**Date and time of transmission:** Friday, May 25, 2018 12:45:10 PM  
**Number of pages including this cover sheet:** 03



**AMENDMENT TO  
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

**WITNESSETH**

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

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2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

**PRACTITIONER**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY****Network Status:** Open**Product Type:** The Health and Fitness Product**Eligible Practitioners:** WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists**Program Design:**

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  - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
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- Address Changes: provider.updates@tivityhealth.com
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1445 S. Spectrum Blvd., Suite 100  
Chandler, AZ 85286  
Attn: Voucher Redemption
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

WHN Choices Voucher Amendment 2.19.2018

# FAX

**To:** [REDACTED]  
**Company:**  
**Fax:** 915594 [REDACTED]  
**Phone:**

**From:**  
**Fax:**  
**Phone:**  
**E-mail:** Marcus.LathamPrice@tivityhealth.com

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## NOTES:

Thanks for taking the time to speak with me twice. You guys are already apart of our network. Because you are apart of Humana with us, you will not be required to submit another contract and I can send you over the info you'd need. Please let me know if you have any questions. Again, no fee schedules associated with the voucher program.

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**Date and time of transmission:** Thursday, February 8, 2018 8:07:20 PM  
**Number of pages including this cover sheet:** 02

Greetings,

My name is Marcus Latham-Price, a recruiter with Tivity Health, WholeHealth Networks.

WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC is currently looking for Chiropractors, Acupuncturists, and Massage Therapist in your area to join our network.

WHN has successfully developed and managed national provider networks for our health plan partners for over 25 years. Joining today will help build your business, increase the visibility of your practice while providing alternative medicine in your community.

We are recruiting for ***Acupuncturist, Chiropractors and Massage Therapist*** for our Health and Fitness product, providing an opportunity to help the 50+ population. This product will have a Complementary Alternative Medicine component providing members with a \$20 voucher to be applied for services.

I'd appreciate the opportunity to discuss this program further to determine if you are eligible and/or interested. I will follow up with you in 2-3 business days via phone.

If you have any questions prior to that, my contact information is below.

We look forward to having you join our network.

Visit our provider website [www.wholehealthpro.com/](http://www.wholehealthpro.com/)

**Marcus Latham-Price** \* Recruitment Specialist

**Tivity Health** \* [tivityhealth.com](http://tivityhealth.com)

☎ \* (480) 692-2703 a \* 1445 S. Spectrum Blvd., Chandler, AZ 85286

[Marcus.Lathamprice@tivityhealth.com](mailto:Marcus.Lathamprice@tivityhealth.com)